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The results of this study demonstrate the effectiveness of the Five Phase Recovery Process as a method of maximizing reimbursements for hospitalization from third party payers under the Third Party Collection Program. The Five Phase Recovery Process was developed by the author and was tested for a six month period at a 65 bed Army Community Hospital. Implementation of the process was in accordance with Deming's Principles of Total Quality Management. The study included a survey of 4500 benificiaries to determine the extent of private health insurance coverage.

At the conclusion of the study, the collection rate increased by 62.66%, the claims paid rate increased by 38.53%, the claims generation rate increased by 120.00%, and overall all collections increased by 350.00% versus the previous fiscal year. The mail survey indicated that 32.95% of the facility's beneficiaries had billable health insurance, but only 6.95% of those with billable policies utilize the facility for their inpatient care.

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A Study of the Efficacy of the Five Phase Recovery Process as a Method of Maximizing Reimbursements under the Third Party Collection Program

A Graduate Management Project

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirements for the Degree

of

Master of Health Care Administration

by

Captain Randy P. Buchnowski, MS

July 1991

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I owe a special thank you to my friends at the Veterans Administration Central Office for allowing me access to their Medical Care Cost Recovery Program.

I would certainly be remiss if I did not acknowledge the support and understanding of my wife. Her constant backing and willingness to accept long hours of research and study, during the past two years, has made this research possible.

ABSTRACT

The results of this study demonstrate the effectiveness of the Five Phase Recovery Process as a method of maximizing reimbursements for hospitalization from third party payers under the Third Party Collection Program. The Five Phase Recovery Process was developed by the author and was tested for a six month period at a 65 bed Army Community Hospital. Implementation of the process was in accordance with Deming's Principles of Total Quality Management. The study included a survey of 4500 beneficiaries to determine the extent of private health insurance coverage.

At the conclusion of the study, the collection rate increased by 62.66%, the claims paid rate increased by 38.53%, the claims generation rate increased by 120.00%, and overall all collections increased by 350.00% versus the previous fiscal year. The mail survey indicated that 32.95% of the facility's beneficiaries had billable health insurance, but only 6.95% of those with billable policies utilize the facility for their inpatient care.

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A Study of the Efficacy of the Five Phase Recovery Process as a Method of Maximizing Reimbursements Under the Third Party Collection Program

I. INTRODUCTION

During the 1980s it became apparent that the rate of growth of Military Health Service System (MHSS) expenditures was substantial. From 1979 through 1987 the outlays for the MHSS increased 171 percent--from $4.1 billion to $11.5 billion (Department of Defense Response to Government Accounting Office Draft Report 393307). In an effort to control this growth, the Department of Defense (DoD), under authority from Congress, implemented a series of programs to reduce the rate of growth of its healthcare outlays.

One of the programs within the direct care component of the MHSS is the Third Party Collection Program (TPCP). The TPCP, formerly called the Coordination of Benefits Program, is authorized by United States Code, title 10, section 1095, enacted as section 2001 of Public Law (PL) 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). The statute allows the Federal Government to

collect (through its military medical treatment facilities [MTF]) from insurance, medical service, or health plans of military retirees and dependents. By collecting from these third party payers, the Federal Government can recover the reasonable costs of inpatient hospital care incurred by the United States at a MTF to the extent that the insurer would pay if the services were provided by a civilian hospital (PL 99-272).

The law was implemented through Department of Defense Instruction (DoDI) 6010.15, dated 4 September 1987. The key provisions of DoDI 6010.15 were:

1. Income maintenance or CHAMPUS supplemental plans are not subject to the TPCP.

2. The amount that may be collected from the third-party payer is the reasonable cost of the care provided less the deductible or copayment amount.

3. Persons covered by private health insurance may not be required to pay deductible or copayment amounts to the United States for inpatient care.

4. Military Services shall establish procedures to document that each dependent or retiree admitted as an inpatient is specifically questioned to determine whether or not they have private health insurance.

5. Accounting records shall be established to be able to report the total amount claimed, the amount collected, and the amount not collected for various reasons.

6. Each military department shall submit a quarterly report on the TPCP to the Assistant Secretary of Defense for Health Affairs (ASD[HA]).

Conditions which Prompted this Study

During fiscal year (FY) 1988 and early FY 1989 the DoD Inspector General (IG) conducted a limited evaluation of the TPCP at all military MTFs and an indepth evaluation of the TPCP at 25 military hospitals. The results were released in DoD Audit Report number 90-105, dated 30 August 1990. At the DoD level, the IG found that:

(1) The Surgeons General and military hospitals did not have sufficient DoD guidance and support to effectively implement and manage the TPCP.

(2) The insurance billing function of the Automated Quality of Care Evaluation Support System (AQCESS) had system problems and was not operational at most hospitals (Audit Report, 1990; Briefing for the Army HSC, 6 Nov 89).

At the MTF level, the Inspector General indicated that the TPCP showed great promise, but had been of limited success because the TPCP had not been effectively nor fully implemented (Audit Report, 1990). For example, in FY 1988, the military departments reported billing a total of $32,732,823 in insurance claims and collecting only $16,231,996--resulting in a "collection rate" of 49.59% ($16,231,996 divided by $32,732,823) (Audit Report, 1990).

I use the "collection rate" or CR as one measure of the overall effectiveness of billing and collection procedures. The CR is defined as the dollar amount of collections divided by the dollar amount of claims.

Table 1 illustrates the amounts claimed, collected, and the resulting collection rate for the Army, Air Force and Navy. For comparison, the CR for civilian hospitals in 1990 averaged 98% (K. Smith, Representative, American Guild of Patient Account Managers, personal communication, 22 November 1990) and the CR for Veterans Administration Medical Centers in FY 1990 averaged 36.18% (N. Howard, Acting Director, Medical Care Cost Recovery Program, Veterans Administration Central Office, personal communication, 15 May 1991).

Table 1

DoD TPCP FY 1988

Military Department	Amount Claimed	Amount Collected	Collection Rate
Army	$15,522,874	$7,808,448	50.30%
Navy	3,278,600	1,511,276	46.09%
Air Force	13,931,349	6,912,272	49.62%
TOTAL	$32,732,823	$16,231,996	49.59%

Source: Adapted from Department of Defense Audit Report number 90-105, Third Party Collection Program (Arlington, Virginia: Inspector General, Department of Defense, August 30, 1990) p. 11.

In addition to low collection rates, the Inspector General found that military hospitals had not established adequate procedures to effectively:

(1) Identify inpatients with health insurance coverage.

(2) Document that inpatients had been questioned about health insurance coverage.

(3) Correctly prepare and submit claims to insurance companies.

(4) Follow up on open claims or resolve claims that were unpaid or partially paid for inappropriate reasons.

(5) Manage the TPCP.

(6) Satisfy internal management control requirements.

At the MTF level, the TPCP was not aggressively pursued (initially) because MTF commanders -- though responsible for initiating, processing and collecting claims -- were not provided the additional resources to accomplish the tasks inherent in third party collections. Furthermore, the funds collected under the TPCP were deposited directly to the United States Treasury (S. Munger, Patient Administration Consultant, Health Services Command, Patient Administration Systems

and Biostatistics Activity, personal communication, 13 April 1990).

As a result, MTF commanders "were hesitant to commit already meager resources to a program that offered very little in return for the effort that was required to make it work" (Memorandum from Alcide M. Lanoue, Major General, Deputy Surgeon General, United States Army to DoD Inspector General, dated 4 June 1990). Since the TPCP could only detract from their health care mission, MTF commanders did not make it a priority for their limited monetary and human resources. Thus, the potential of the TPCP was not fully realized and it came under the scrutiny of the DoD Inspector General and the GAO.

In response to this dilemma, DoDI 6010.15 was revised (in accordance with Section 9109 of the National Defense Authorization Act for FY 1990, PL 101-89 and PL 101-165). In addition to changing the name of the program from the "Coordination of Benefits Program" to the "Third Party Collection Program," these laws directed that:

(1) Effective 1 October 1989, money recovered under the TPCP could be retained by the collecting MTF

and obligated as normal operational and maintenance funds.

(2) Funds collected by hospitals pursuant to this program, except for amounts used to finance collection activities, were to be used to provide enhanced health care services to beneficiaries.

These changes provided MTF commanders with the economic incentive to shift resources to the TPCP and to aggressively initiate and collect on private insurance claims. As illustrated in Table 2, the changes had an immediate impact and resulted in a doubling of Army MTF claims and collections (however, the collection rate decreased by three percent).

The results in Table 2 are for FY 1990 (1 October 1989 through 30 September 1990). The Army Health Services Command (HSC) figures are for the 37 MTFs evaluated by the DoD IG in FY 1988 and FY 1989 (excluding Brooke Army Medical Center which was not part of HSC during the study, and including Gorgas Army Community Hospital (Panama) which is now in HSC [but for which no collections were reported]). Statistics for Keller Army Community Hospital (KACH), the subject hospital for this study, are introduced here and are included in future tables for analysis.

Table 2

HSC TPCP FY 1990

	Amount Claimed	Amount Collected	Collection Rate
HSC	$33,274,227.18	$15,495,325.57	46.57%
KACH	$100,590.00	$40,248.12	40.01%

Source: TPCP Print Out: First, Second, Third and Fourth Quarters of FY 1990, dated 6 November 1990, Resource Management Division, Health Services Command, Fort Sam Houston, Texas.

NOTE: The collection data listed in the "amount collected" column are not updated after the end of the fiscal year. That is, HSC uses a cash basis of accounting in which claims pending at the end of FY 1990 are credited to FY 1991 rather than the year the claim was generated.

A second measure of the effectiveness of billing and collecting procedures is the "claims paid rate" or CPR. The CPR is defined as the number of claims paid divided by the number of claims generated. A CPR of 100% means that some amount was collected on every claim submitted.

The CPR complements the CR and can be used to monitor the overall effectiveness of the recovery process. For example, a CPR of 100% and a low CR indicates that some amount was received on every claim, but something less than the full value of the claim. This situation could result from a number of factors. For instance, insurance policies with high copayments and/or deductibles yield less revenue than policies with low or no copayments and deductibles. Inadequate compliance with utilization review requirements may result in the third party payer withholding a portion of the payment as a penalty. Or, perhaps the MTF could not justify, to the insurance carrier's satisfaction, a portion of a patients treatment (e.g., length of stay) and therefore the company paid less than the full amount of the claim.

The other extreme is a low CPR and a high CR. In this situation, the MTF is not collecting on some

claims, but on others they might be collecting the full amount of the claim. This circumstance suggests several potential problems. For example, a training or personnel problem where a clerk is submitting inappropriate claims or forms with errors (e.g., submitting claims to an insurance plan not liable under the TPCP). The problem could also lie with an insurance company who refuses to pay federal facilities. Or perhaps, the MTF is billing for procedures performed on an inpatient basis which the third party payer considers to be appropriate for an outpatient setting.

In FY 1988, the mean CPR for the HSC MTFs sampled by the DoD Inspector General was 69.41% (Table 3) with a range of 14.09% to 88.20% (Audit Report, 1990). Thus, some MTFs received payment on only 14 of every 100 claims while others received payment on 88 of every 100 claims. Overall, HSC MTFs received payment on only two-thirds of all claims submitted in FY 1988.

In FY 1988, the CPR for KACH was 33.33% (Table 3) and in FY 1990 it had increased to 53.85% (Table 4)--a difference of 62%. I expect that the regulatory changes to the TPCP resulted in a similar improvement for the HSC. I cannot verify this because the HSC only

tracks the number of claims generated, not the number of claims MTFs receive payment on.

The financial impact of poor billing and collection procedures is compounded by the fact that military hospitals are not adequately identifying inpatients with health insurance. According to the DoD Inspector General, 6.11% of the inpatients who answered their FY 1988 survey questionnaire had health insurance coverage (Audit Report, 1990). The IG considers this percentage low since retirees and dependents are reluctant to volunteer health insurance information (Audit Report, 1990; GAO/HRD 90-64, 1990).

To measure the effectiveness of the procedures used to identify patients with health insurance I use the term "claims generation rate" or CGR. The CGR is defined as the number of claims generated divided by the number of inpatient admissions. The higher the CGR the greater the effectiveness of identification procedures. The CGR is valid based on the assumption that insurance companies of patients with billable policies are charged for the care provided by MTFs.

As shown in Table 3, the mean CGR for the seven HSC medical centers sampled by the DoD IG in FY 1988 was 2.35% (2337 claims divided by 99,540 inpatients) with a

range of 0.25% to 10.55% (Audit Report, 1990, p. 31). The CGR for KACH in FY 1988 was 0.13%. As expected, the 1990 changes to the TPCP helped boost identification rates and in turn the CGR increased. Table 4 shows the CGR for HSC and KACH for FY 1990.

Table 3

HSC CGR and CPR for FY 1988

	Total Inpatients	Claims Generated	Claims Paid	CGR	CPR
HSC	99,540[a]	2,337[a]	1622	2.35%	69.41%
KACH	4,804[b]	6[c]	2	0.13%	33.33%

Source: [a] Obtained from DoD Audit Report number 90-105. These figures are the totals for the sampled medical centers (Eisenhower, Tripler, Madigan, Fitzsimons, Walter Reed, Letterman and William Beaumont).

[b]Obtained from the KACH Workload Statistics for FY 1988.

[c]Obtained from HSC TPCP print outs for the four quarters of FY 1988.

Table 4

HSC CGR and CPR for FY 1990

	Total Inpatients	Claims Generated	Claims Paid	CGR	CPR
HSC	338,976[a]	13,574[c]	N/A	4.00%	N/A
KACH	4,722[b]	65[d]	35[d]	1.38%	53.85%

Source: [a]Calculated from HSC Command Performance Summary, Fourth Quarter, FY 1990 (average daily admissions per day for the HSC of 928.7 x 365 days = 338,976).

[b]Obtained from the KACH Workload Statistics FY 1990.

[c]Obtained from the TPCP print out for the First, Second, Third and Fourth Quarters of FY 1990, dated 6 November 1990, Resource Management Division, HSC, Fort Sam Houston, Texas.

[d]Obtained from the KACH Treasurer's TPCP Memorandum, dated November 1990.

N/A means the information is not available.

Tables 1 through 4 illustrate the effectiveness of the changes to the TPCP. During FY 1990 (the first year in which MTFs were allowed to retain collections) commanders geared up the TPCP and generated significantly more claims and collected noteably more revenue than in FY 1988. In FY 1988, HSC's collection rate of 50.30% resulted in collections worth $7,808,448. In FY 1990, HSC's collection rate decreased to 46.57%, yet collections increased to $15,495,325. The 3.73% decrease in the HSC collection rate between FY 1988 and FY 1990 may be partially attributed to the large value of claims pending ($676,026) at the end of FY 1990. If MTFs collect 46.57% (the CR for FY 1990) of this amount, the overall collection rate would increase to only 47.52%, still 2.78% below the 50.30% level of FY 1988.

The real doubling of collections between FY 1988 and FY 1990 ($15,495,325 versus $7,808,448) gives the illusion that billing and collection procedures are improving and a more effective system is evolving. In reality, MTFs are identifying a greater proportion of inpatients with private health insurance and are therefore generating more claims. They have not,

however, improved the effectiveness of the collection system as measured by the CR.

In contrast with HSC, the CR for KACH actually increased between FY 1988 and FY 1990. In FY 1988, the 32.24% CR resulted in $3,128.00 worth of collections. In FY 1990, the 40.01% CR netted collections worth $40,248.12. However, the FY 1990 CR is 86% of the CR for the HSC and indicates that KACH is only collecting forty cents of every dollar billed.

The effectiveness of the procedures by which HSC MTFs identify patients with private health insurance improved between FY 1988 and FY 1990. During this period the HSC CGR increased by 67.72% (3.47% versus 2.35%). However, this is less than half of the 7.69% rate anticipated by the Inspector General and less than one-third of the 10.55% experienced by HSC's best performing MTF (Audit Report, 1990). KACH's CGR is 1.38%, less than half the HSC rate.

Comparing the CGR from MTF to MTF, or establishing a standard CGR should be done cautiously since health care is a local phenomenon and a number of factors influence (1) the decision to purchase third party coverage and (2) the decision to utilize a military MTF for care. Though a low CGR may be an indicator of weak

identification procedures at the local level, it is also probable that wide variations among MTFs only indicates different usage patterns among beneficiaries with health insurance. These differences may be attributable to geographical barriers, competition from civilian hospitals, unemployment or other financial conditions, insurance policy limitations, and ease of access (such as appointment availability). For these reasons, useful identification goals should be formulated locally. That is, each MTF must identify for itself those beneficiaries in its catchment area with billable insurance who utilize the MTF.

Table 5 presents a summary of the definitions and purposes of the key ratios. It also introduces standards by which to evaluate these ratios. Table 6 depicts a performance summary for both HSC and KACH.

Comparing past rates to their standards reveals the costliness of ineffective procedures used to (1) identify patients with health insurance and (2) to generate and collect on claims. According to the IG's figures, HSC MTFs lost $23,667,682 in potential revenue in FY 1988. And KACH lost approximately $171,613 during the same period. If these procedures are not

improved, HSC MTFs stand to lose another $149,900,000 from FY 1990 through FY 1994 (Audit Report, 1990).

The loss of TPCP revenue to KACH may be more significant in the future based on the possibility that the AMEDD, and therfore MTF, budget will be decremented in anticipation of collections greater than those accomplished.

Evaluation of the TPCP at KACH

At KACH, responsibility for the TPCP rests with the Chief, Patient Administration Division (PAD). Within the PAD, admission clerks are responsible for interviewing and identifying patients with private health insurance. During my evaluation I found their patient identification procedures to be cursory. Admission clerks interviewed patients to determine if they had health insurance. If the patient denied having insurance, a "Coordination of Benefits-Insurance Information Form" was completed and then discarded. No attempt was made to educate the patient or to further elicit third party coverage. If the patient had insurance, the "Coordination of Benefits-Insurance Information Form" and the "Authorization for Assignment of Benefits Form" were completed and routed along with

a copy of the patient's insurance card to the Hospital Treasurer.

The Treasurer is responsible for billing and collecting from third party payers. Billing procedures consisted of the Hospital Treasurer generating a UB-82 from the AQCESS and manually entering the MTF's zip code, telephone number and other required data and then mailing the form to the address listed on the insurance card. Utilization review was not part of the TPCP. Collection activities did not exist other than resubmitting a copy of the UB-82 after a 90 day interval. Referral of problem cases to the Staff Judge Advocate were nonexistent.

Problem Statement

The problem of this study is to determine the procedures by which KACH can effectively identify patients with private health insurance billable under the TPCP and then efficiently and effectively bill and collect from third party payers.

Table 5

SUMMARY OF KEY RATES

Rate	Definition/Purpose/Standard
Collection Rate (CR)	Definition: Dollar amount of collections / dollar amount of claims. Purpose: Measures the overall effectiveness of the billing and collection process. Standard: 100% net of copayment and deductibles.
Claims Paid Rate (CPR)	Definition: Number of claims paid / number of claims generated. Purpose: Measure effectiveness of collection process. Standard: 100%.
Claims Generation Rate (CGR)	Definition: Number of claims generated/number of admissions Purpose: Measure effectiveness of identification process. Standard: Establish locally.

Table 6

KEY RATE COMPARISON: HSC vs KACH

	HSC		KACH	
	FY 1988	FY 1990	FY 1988	FY 1990
CR	50.30%	46.57%	32.24%	40.01%
CPR	69.41%	N/A	33.33%	53.85%
CGR	2.35%	3.47%	0.13%	1.38%

Literature Review

Total Quality Management

During my literature review of the TPCP, I wanted an underlying theme or philosophy upon which to analyze the literature and to guide implementation of yet to be developed TPCP procedures. I selected the Total Quality Management (TQM) philosophy of W. Edwards Deming and J. M. Juran. Total quality management emphasizes continuous quality improvement with a focus on the customer. Though used extensively in the industrial sector, TQM has enjoyed growing acceptance by health care institutions -- including the nation's largest chain of hospitals, Hospital Corporation of America (Batalden, 1988; Duncan, 1991). In addition, the DoD has accepted and implemented TQM guidelines (DoD TQM Master Plan, 1988).

Applying TQM principles to the TPCP requires adherence to Deming's 14 Points for Managers. These are:

1. Create a constancy of purpose for the improvement of product and service. This means that we must focus on innovation, research and constant improvement of our identification, billing and collection procedures.

2. Adopt the new TQM philosophy. This means transforming from a focus on quotas to one of quality and instituting a "corporate culture" that emphasizes quality. It is more productive to submit insurance claims without defects than to risk non-payment or have to resubmit claims a second or third time due to errors.

3. Cease dependence on mass inspection. Rather than inspecting bad quality out we must build quality in. The concept is to change from inspecting for defects/errors to preventing these errors in the first place.

4. Stop awarding business on price tag alone. This point does not apply specifically to the TPCP (unless of course the claims process is performed by a contractor) but it contains an important subelement--building long-term relationships with your customers (e.g., third party payers). As MTFs venture into the competitive world of commercial health insurance it is imperative that we develop trusting relationships with our third party payers and that we (both the MTF and the DoD in general) are known as providers of quality, cost-effective health care.

5. Improve constantly and forever the system of production and service. Improvement is not a one-time effort. Management must lead the way and look for ways to reduce waste and improve quality. Quality begins at the design stage and teamwork is essential to the process. Teamwork is an critical component of the TPCP since a successful program requires the input and cooperation of admissions personnel, billing clerks, resource management clerks, nurses, physicians, utilization management personnel, and patient administration specialists.

6. Institute training and retraining. Be proactive in the supervision of employee training. Do not allow workers to learn their job from other employees since they can only teach what they are doing. Some of these ways might be correct and some might be wrong. This concept applies not only to the individual employee but to the organization as well. Consider the MTF as the employee, HSC as the supervisor, and the TPCP as the new job. The employees (MTFs) are told to institute a new program (TPCP) without training from the supervisor (HSC). The untrained employees (MTFs) implement by trial and error and often call other inexperienced employees (MTFs)

seeking guidance. The other employees (MTFs) can only guide through their experience and frame of reference, which may or may not be correct.

This point suggests an important course of action. That is, find a supervisor knowledgable in the ways of billing and collecting from third party payers and learn from them. For example, find a civilian hospital or another federal agency with a successful patient accounting or business office. Study their methods and implement those procedures which fit your organization.

On the clerical level, it is important to realize that most employees performing TPCP tasks were not originally hired or trained to perform these tasks. We are asking them to perform new functions that may be beyond their skill level. Managers must identify these workers and provide the training necessary to increase their abilities.

7. Institute leadership. Leadership is the job of management. Management must discover barriers that prevent workers from doing their jobs correctly. To do this, managers must know the work they supervise.

8. Drive out fear. Employees should not be afraid to point out problems for fear of argument or being blamed for the problem. If employees are afraid to

admit mistakes then the mistakes will never be corrected. The TPCP should be most successful in organizations without fear since their employees are free to express ideas, ask questions and ask for additional instructions.

9. Break down barriers between staff areas. The organization must work towards the same goals and solve problems as a team. Admissions clerks, nurses, physicians, utilization review personnel, medical records specialists and the others involved in the TPCP may work superbly in their respective departments. But if their goals are in conflict the program will not be a success. The success of the TPCP rests with those people who work in the system and with the manager who works on the system. The active support of the commander and deputy commanders for the TPCP is a prerequisite for a successful program since they have the power to unify the administrative and clinical staffs.

10. Eliminate slogans, exhortations, and targets for the workforce. For the most part, low productivity (e.g., low collection rates) belongs to the system and therefore lies beyond the power of the employee. Establishing goals without a method of reaching them is

useless since employees cannot perform outside the system.

11. Eliminate numerical quotas. Employees will meet them at the expense of quality.

12. Remove barriers to pride of workmanship. Train employees to do their jobs correctly and give continuous feedback. Provide the equipment to do the job.

13. Institute a vigorous program of education and retraining. Employees must continuously acquire new knowledge and skills. TPCP specialists cannot perform adequately without learning interviewing techniques, billing requirements, collection procedures, and database and spreadsheet skills. Once they have developed these skills they will need to learn how to use the AQCESS (Automated Quality of Care Evaluation and Support System). As the TPCP expands (e.g., billing for outpatient care) they will have to learn a whole new set of skills.

14. Take action to accomplish the transformation. Organize management to advance the other 13 points. Follow the Shewhart Cycle: Plan, Do, Check, Act. Plan the study of a process, decide what change might improve it, organize an action team; carry out tests;

observe the effects; study the results of the test (Deming, 1986).

Deming's 14 Points provide organizational and managerial guidance applicable to the TPCP system. The TPCP system consists of interrelated subsystems. Sort of like Chinese boxes in that it contains wholes with wholes. One of these boxes contains the recovery process. The recovery process is a concept I use to describe the procedures used to identify patients with health insurance and to bill and collect from insurance carriers.

The recovery process is the operational aspect of the TPCP which has been implemented ineffectively and is, as of yet, undefined. The recovery process can be conceptualized as a series of five sequential phases. These five phases are discussed in detail in the next section.

The Five Phase Recovery Process

The procedures by which MTFs identify patients with private health insurance and then bill and collect from third party payers were established by DoDI Number 6010.15, dated 4 September 1987. This DoDI was further clarified by each of the Military Departments in

subsequent implementating guidance. The guidance for the Army consisted of two basic requirements:

(1) Upon admission to a MTF, retirees and dependents will complete a "Declaration of Benefits" form stating whether or not they have health insurance. If they have private health insurance, then an "Assignment of Benefits" form is completed.

(2) MTFs are responsible for preparing bills to private insurance carriers using the UB-82/HCFA 1450 form.

These requirements actually include a number of processes which can be grouped into five distinct phases. These are:

1. Identify patients with health insurance.
2. Fulfill utilization review requirements.
 - pre-admission
 - concurrent
 - post-discharge
3. Bill the insurance company.
4. Collect from the insurance company.
5. Refer problem cases (if required).

These five phases can be further broken down into a series of 11 steps:

(1) Interview inpatients about insurance.

(2) Identify those with billable policies.

(3) Collect appropriate insurance data.

(4) Identify and comply with pre-admission utilization review requirements. These vary by policy and are based on whether the admission is elective (scheduled) or emergency (unscheduled).

(5) Identify and comply with concurrent utilization review requirements.

(6) Prepare the bill (UB-82).

(7) Process/verify accuracy of the bill.

(8) Mail bill to insurance company.

(9) Identify and comply with post-discharge utilization review requirements and supply other data requested by the third party payer.

(10) Close the case if full payment (defined as the amount billed minus the patient's deductible and copayment) is received.

(11) Conduct additional collection activities if full payment is not received. These activities include resubmitting the claim, submitting additional justification, or refering the case to the Staff Judge Advocate.

The importance of phases one, three and four are obvious in that they serve as the foundation of the

TPCP. Weakness in any of these phases has a detrimental affect on collections. The DoD Inspector General's 1989 survey of MTFs discovered that ineffective procedures were being used to identify patients with health insurance and to bill and collect from insurance companies. Similar deficiencies were found by the Air Force Audit Agency in their 1988 study of 17 Air Force MTFs (Report of Audit, 1989). In addition, the United States Government Accounting Office (GAO) found these same weaknesses in their FY 1988 evaluation of Veterans Administration Medical Care Cost Recovery Programs (GAO/HRD-90-64, 1990).

In contrast to phases one, three, and four, phase two (utilization review) is not recognized as an important element of the TPCP. It was not specifically addressed in DoDI 6010.15 nor in the Army's Implementing Guidance. In addition, utilization review procedures were not identified, and therefore not evaluated, in the 1990 DoD IG Audit Report or the 1989 Air Force Report of Audit.

The true value of utilization review may be better appreciated by looking at agencies outside the DoD. The Veterans Administration (VA) encourages its medical centers to incorporate utilization review procedures in

local Medical Care Cost Recovery Programs (MCCR). The MCCR program is a similar though broader version of the TPCP and it allows VA Medical Centers to bill for both inpatient and outpatient care. Seventy-eight percent of VA facilities include utilization management staff in the MCCR. The success of the VA program is evidenced by their 159 medical centers which collected $100,000,000 in FY 1988 versus the DoD's 129 MTFs which collected $16,231,996 in FY 1988 (GAO/HRD-90-64, 1990; Audit Report, 1990).

Further proof of the importance of utilization review was demonstrated by a survey of 19 hospitals in the Northern Metropolitan Hospital Association (NORMET) (NORMET is an association of hospitals located in the counties neighboring New York City. KACH is a member of this organization). The results indicated that 2.51% (12 out of 517) of the claims to Blue Cross were initially denied and required justification by a hospital's utilization review office prior to payment (NORMET Patient Accounts Managers Sub-Committee, 1990).

In addition, utilization review, in the form of precertification of each hospital admission, is a mandatory provision of the Federal Employees Health Benefits Program. In this program it is the patient's

responsibility to ensure that the precertification requirement is met (1991 Federal Employees Health Benefits Program Enrollment Information Guide and Plan Comparison Chart).

Utilization review clauses affect MTFs because monetary penalties are assessed for not meeting prerequisites. In civilian health care, many of these penalties (money the third party payer withholds for noncompliance) become the responsibility of the patient since it is the patient who is ultimately responsible to the hospital for paying the bill (in New York State, hospitals post signs to this effect outside their billing offices warning patients that the hospital bill is their responsibility). This is not the case with the DoD and the TPCP. The patient has no financial responsibility and therefore no incentive to comply with or to help identify utilization review requirements.

When the MTF does not meet utilization review provisions, the insurance carrier imposes a penalty and thereby saves money, the patient is unaffected, and the MTF loses an amount equal to the penalty. Thus, the onus to identify the existence and extent of utilization review clauses is on the MTF.

The fifth phase of the recovery process involves the referral of problem collection cases to the military Staff Judge Advocate (SJA). The circumstances in which the SJA would get involved include situations in which an insurer pays the patient rather than the MTF and subsequently refuses to pay the MTF; when the insurer refuses to pay Federal facilities; or when insurers fail to respond to billing and follow-up efforts. In effect, the SJA represents the MTF in resolving payment disputes.

Each phase of the five phase recovery process is significant in that the success of subsequent phases relies on the quality of previous phases. Each phase is described in detail in the next section. Each description contains:

(1) An explanation of how to perform the procedure.

(2) The difficulties involved in performing the procedure.

(3) How to monitor the procedure for effectiveness.

Phase One -- Identification

The recovery process begins with the identification of billable cases. This phase consists of two steps

which can be performed by the admissions clerk. The first step is to interview retirees and dependents during the admissions process to determine if they have private health insurance. The second step is to determine if the insurance policy is billable. Verifying the type of insurance is important since many types of insurance are not billable under the TPCP at this time (e.g., CHAMPUS and Medicare supplemental policies) (DoDI 6010.15; Audit Report, 1990).

Identifying beneficiaries with health insurance is difficult because (1) patients are reluctant to identify themselves as having insurance and (2) there are no real penalties for noncompliance. Preliminary research suggests four main reasons for this reluctancy. These are:

(1) Patients believe that military health care is a right they have earned. Whether or not they have health insurance is none of our business.

(2) Patients fear their health insurance rates will increase if their insurance company is billed.

(3) Patients are concerned that they will become responsible for deductibles or copayments.

(4) Patients fear that disclosure of insurance will affect their access to free health care at

military MTFs (Fact Sheet, Subject: Third Party Collection Program, dated 16 October 1990, Walter Reed Army Medical Center).

To identify the existence of other barriers to the identification process I randomly interviewed patients and family members during and subsequent to admission to KACH. During these informal interviews, I found that patients consistently believe that questions about insurance do not pertain to them. It was as if they quit listening as soon as the word "insurance" was mentioned. As far as they were concerned, they are military beneficiaries and treatment in a military health care facility is free. Therefore, questions pertaining to insurance just don't apply to them. Thus, admission clerks must be skilled at educating the patient and creating a cordial atmosphere which is conducive to eliciting the requisite information.

A second barrier to identifying patients with insurance is the relatively recent implementation of the TPCP by the MTFs. Previously, determining the billability of a patients insurance was not a part of day-to-day business. Just a few years ago, patients admitted to a military MTF were not questioned about their insurance coverage. Now, it is in the best

interest of the MTF to identify each inpatient with private health insurance.

The problem is that we have not adequately informed our patients about the program and our new regulations require us to ask indepth questions about their insurance coverage at an inopportune time--the time of their admission. When patients are admitted to the MTF, health insurance is probably not on their minds and the quickest/safest answer is that they do not have health insurance.

Thus, it might benefit MTFs to aggressively market the TPCP to target beneficiaries, introduce them to the TPCP and perhaps gather health insurance information prior to admission.

Identifying patients with health insurance and eliciting insurance information can be improved by training admission clerks to be creative and ask open ended questions. For example, rather than asking if a patient has health insurance, ask questions such as:

"If you were in a private hospital, who would pay your bill?"

"Where are you employed?"

"Where is your spouse employed?"

The idea is to conduct business as if asking questions about a patient's insurance coverage is a normal part of the admission process. In a nonmilitary hospital this is normal procedure.

If the patient cannot be interviewed, then the patient's spouse or family should be interviewed for this information. Furthermore, all inpatients could be reinterviewed the business day after admission to verify insurance information and to determine the effectiveness of the admission clerk's screening (Veterans Administration, National Training Seminar, 1990).

Key indicators of insurance which can be used to identify, pursue, or reinterview patients who deny having insurance are:

(1) Employment. Patients who are employed are likely to be insured.

(2) Income level. High income levels correlate with having health insurance.

(3) Previous insurance coverage. Those who once stated that they had health insurance probably still do (VA National Training Seminar, September 1990).

The first step of the identification phase is concluded when the beneficiary signs the "Coordination

of Benefits -Insurance Information" Form (Form DD2502) upon which they certify that they do or do not have health insurance.

The second step of the identification phase is to further interview those with health insurance to determine if their policies are billable. This step is challenging since most patients are not sure whether or not their insurance is billable, and if it is, they do not know the extent of their coverage. Unless the person gathering the insurance information is familiar with the policy, the insurance company must be contacted to determine billability. This procedure can be conducted by the MTF's insurance coordinator or the person who bills third party payers. After it is determined that the policy is billable, the patient signs the "Authorization for Assignment of Benefits" Form which authorizes the insurance company to pay the MTF. This is the end of the patient's role in the TPCP.

During the identification phase, it is essential to obtain accurate, reliable, and confirmed information about the patient's health insurance since it is the basis for future billing and collection activity. The following critical information should be verified:

- patient's legal name and address.

- date of birth (for coordination of benefits purposes).

- place of employment (complete name).

- employer's address, phone number, and a point of contact.

- insurance coverage.

- where to send claims and what attachments are required.

- specific requirments of the HMO, employer, or insurance company (Mowll, 1990).

Verification of insurance information is a two step procedure.

1. Contact the patient's employer to verify the kind of insurance and the benefits available to the patient. They will verify the patient's eligibility. Sometimes the employer is the initial processing agent for insurance claims. If so, they will be able to tell you what kinds of prior authorizations and second opinion clauses exist in the contract.

2. Contact the insurance company. Once you know the patient is eligible, the insurance company can tell you what prior authorization steps exist. They will

also give you billing addresses and information regarding benefits not obtained from the employer.

When calling the insurance company be prepared to provide the following information:

a. Insurance group number.

b. Patient social security number.

c. Diagnosis. Know the first date of treatment for this problem. Knowing the International Classification of Diseases-9-Clinical Modification Code (ICD-9 CM) will also help.

d. Know the planned procedure.

The insurance company will give you an authorization number and the number of days that are authorized. Failure to comply with pre-admission requirements can result in as much as a 50% reduction in benefits (Jenings, 1989; Mowll, 1989).

Obtaining or verifying the telephone numbers and addresses of insurance companies can sometimes be difficult. One method of getting this information is through the "Insurance Phone Book & Directory." This book is a quick reference directory encompassing insurance companies in all 50 states. I have provided ordering information in Appendix A.

In addition to identifying new inpatients with health insurance, the MTF can take steps to identify and bill the insurance companies of former inpatients who had not been identified as having insurance or whose insurance carriers had not been billed. This can be accomplished by performing a survey of previous inpatients with unknown health insurance coverage and then generating claims. The MTF may be required to obtain the permission of the third party payer to bill them if claims are old. For example, Empire Blue Cross and Blue Shield of New York State allowed KACH to generate claims for retiree and dependent inpatients back to 21 September 1988. This date was agreed upon based on the date of our last accreditation by the Joint Commission on Accreditation of Healthcare Organizations.

A more thorough method of identifying previous patients with health insurance is to survey the entire population eligible for the TPCP. The results of this type of survey are valuable for billing the insurance companies of previous inpatients, for establishing a range for the CGR, and for streamlining the admission process since insurance information could be recorded on the AQCESS.

The effectiveness of the procedures used to identify retirees and dependents with health insurance can be measured by the CGR. As identification rates rise, so should the number of claims generated relative to the total number of inpatients.

Phase Two -- Utilization Review

The goal of utilization review or utilization management, is to promote the effective and efficient use of available health resources and services while maintaining quality patient care (Veterans Administration, National Training Seminar, 1990).

Private health insurance plans employ a variety of cost containment measures, under the umbrella of utilization review, that impose various requirements on MTFs that must be met in order to receive maximum reimbursement. These requirements include preadmission certification, second surgical opinion, and the review of medical records (concurrently and/or retrospectively) for appropriateness of admission or continued length of stay, and timeliness of services.

In addition, most private health plans want to verify that the patient is receiving treatment in the most appropriate, economical and safe setting. Complying with these requirements should be part of an

MTFs plan to secure maximum reimbursement from third party payers.

In 1987, the DoDI 6010.15 did not specifically address utilization review. Today, MTFs cannot ignore these requirements because third party payers are increasingly enforcing utilization review criteria based on studies which have shown that up to 30% of all health care services are unnecessary (Chassin, 1990). In fact, The Health Insurance Association of America claims that "the greatest waste of health care dollars is in payments for medical and surgical procedures that are not necessary" (Kahn, 1991, p. 7).

Perhaps the two greatest difficulties encountered in complying with utilization review requirements are (1) identifying that a requirement exists and (2) understanding specifically what the requirement means to the individual insurance carrier.

Identifying utilization review requirements is usually a matter of telephoning the insurance carrier (the telephone number is generally on the patient's insurance card). The MTF should provide the following information when contacting an insurance company:

- The policy holder's name, social security number, address, telephone number and policy number.

- The patient's name, birthdate, social security number, and relationship to policy holder.

- The policy holder's employer's name and plan number.

- The point-of-contact for the MTF.

- The MTF name, address, telephone number, and provider number.

- The reason for admission and/or the type of treatment being provided. Include the ICD-9-CM codes, patient history and physical, anticipated treatment plan, and expected length of stay (Handbook, 1990).

The insurance company's determination to certify the admission is based on pre-established criteria, such as the "Appropriateness Evaluation Protocol" or "Intensity of Service, Severity of Illness and Discharge Screens" (Handbook, 1990).

The following information should be obtained from the insurance carrier:

- Authorization number.

- Number of days certified (the number of days the insurance company will pay).

- Insurance coverage (co-payment and deductible, coverage provided, coverage limits)

- Requirements for additional review and time frames due.

- Verification of policy number, group number, point of contact (Handbook, 1990).

Preadmission review/certification is required by most insurance companies and can be accomplished via a telephone-based review system. In the case of elective/scheduled admissions the MTF is responsible for contacting the insurance carrier to initiate the review prior to admission. In the case of non-elective admissions (e.g., emergent or urgent) the insurance carrier is typically contacted by the end of the second working day after admission. Third party payers generally employ nurse reviewers who will check the patient's eligibility and health benefits.

If the insurance company does not certify the admission, the MTF should be informed of the reason for denial (e.g., the condition was pre-existing to the patient's insurance coverage) and the MTF should request that denial notification be sent in writing so the MTF can include the denial statement in the patient's file. Finally, the insurance company should be asked for reconsideration/appeal procedures and time frames for submission.

Another cost containment technique used by insurance companies is the second surgical opinion. Because this measure is so expensive and because savings vary widely by procedure it is usually not used except for the most costly cases (Barr, 1990). When a second surgical opinion is required, the insurance company will tell the MTF who is to provide it and it is up to the patient to make all arrangements. After the patient has been seen, the insurance company notifies the MTF of the results of the second opinion.

Sometimes the information supplied to the insurance carrier is not sufficient to justify the admission. They may request additional information or to speak directly to the utilization review office or the physician involved.

If the insurance company requires continued stay reviews, then the office conducting these reviews must be made aware of the requirement so they can comply with the insurance company's provisions. These reviews are usually performed the day before the patient reaches the previous number of certified days. Whether the MTF notifies the insurance company or vice-versa, the continued stay review should include changes in the patient's condition and treatment plan that require the

need for continued hospitalization. If the insurance company's review nurse does not approve of the need for continued stay then the attending physician may need to speak with the company's medical director. If the insurance company finds that continued stay is inappropriate this should be made known to the MTF within one day. The MTF can dispute the finding by requesting, in writing, a formal appeal.

Incorporating the utilization review process into the TPCP requires training the admissions clerks, insurance coordinator, medical staff and other personnel as appropriate, to identify and comply with pre-admission utilization review requirements.

The effectiveness of the utilization review system can be tracked in general by the CR and CPR. For example, a low CR and a high CPR indicates that payment is received on most claims but not in full. A more detailed tracking system involves measuring the number of cases in which payment is denied or reduced because of noncompliance with utilization review procedures. This may become the standard method of monitoring the effectiveness of an MTF's utilization review program since the new TPCP DoDI requires quarterly reports

which state the dollar amount not collected due to noncompliance with utilization review procedures.

Phase Three--Billing

After the patient has received care, the third party payer must be billed for all allowable costs. In general, the billing phase involves two steps (1) determining charges according to the rate schedule prepared by the Assistant Secretary of Defense (Comptroller), and (2) correctly preparing and submitting the Uniform Bill-82 Form (UB-82) to third party payers.

The Comptroller's rates are subdivided into three categories:

i. Hospital charges.

ii. Physician charges.

iii. Ancillary charges.

Billing insurance carriers under the TPCP is affected by the following provisions of DoDI 6010.15:

(1) If the third party payer can demonstrate prevailing rates lower than those established by the Comptroller, bill at the lower rate.

(2) Retirees and dependents are not required to pay the MTF the amounts of deductibles, copayments, or penalties imposed by the third party payer.

(3) Separate claims are to be made for mother and baby in an inpatient delivery case.

(4) Third party payments to patients do not constitute payment to the MTF under the TPCP.

The majority of difficulties in the billing phase concern the preparation and submission of the UB-82 (Audit Report, 1990). There are several factors which complicate efforts to properly prepare and submit insurance claims. One factor is the UB-82 itself.

The UB-82 is the standard form developed by the National Uniform Billing Committee and used for billing purposes. It is a form that attempts to be all things to all carriers. Most blocks on the UB-82 are filled out in accordance with National Uniform Billing Data Element Specificiations. However, some data definitions vary among states and by payer. And undefined fields are used differently by each payer (Gardner, 1990). In addition, health insurance is heavily regulated by states and there is little standardization between carriers.

Another problem is the number of carriers and sources of coverage. In the United States there are approximately 1,000 companies that sell health insurance and most corporations with over 1,000

employees are self-insured. Self-insured firms provide health care coverage for their employees without the benefit of an insurance company (M. Marsh, Public Relations Director, Health Insurance Association of America, personal communication, 27 May 1991). And not all organizations are standardized. For example, the Blue Cross and Blue Shield Association is the coordinating agency for 74 locally managed and governed corporations called "plans." Each is virtually independent.

Because of this diversity, the UB-82 is complex and time consuming to fill out. As a result, DoD billing guidance has been necessarily vague since insurance policies and types of coverage vary with state laws and consumer demands in different geographic locations. Thus, it is up to the MTF to ascertain the specific coverage of the patient and how to correctly prepare and submit claims to each third party payer.

The billing function is made more complex for patients covered by more than one insurance carrier. In these cases, an original bill is sent to each carrier. The carriers then make the coordination of benefits determinations (e.g., who is the primary and secondary payer).

Another factor which complicates the billing process concerns releasing sensitive medical information. Information related to HIV testing or treatment, sickle cell anemia, or alcohol and drug abuse treatment is considered sensitive by most agencies (Handbook, 1990). Though not addressed in the DoDI, I feel we have an ethical obligation to the patient to obtain their specific authorization prior to disclosing sensitive information on the UB-82.

Billing errors in MTFs generally concern submitting claims with (1) incorrect user identification or enrollment codes, (2) incomplete principal diagnoses and other diagnoses, or (3) to the wrong insurance office (Audit Report, 1990). In its audit, the DoD IG did not measure or calculate billing error rates.

Surveys of the billing error rates of civilian hospitals indicate that the better performing hospitals have error rates as low as two percent, while other hospitals have error rates as high as 20% (Dingess, 1989). Another study found that it is not unusual for a hospital to have a billing error rate of 25%-30% (Souders, 1990).

A VA study found that the most common errors on billing forms are:

(1) Diagnosis missing.

(2) Improper surgical procedure number.

(3) Patient's name and insured's name used as the same when the dependent is the patient.

(4) Provider's address missing.

(5) Illegible billing form submitted.

(6) Missing location code (where services were rendered, e.g., hospital) (VA Training Seminar, September, 1990).

The possibility of high billing error rates and the resultant impact on revenue compels many civilian hospitals to use electronic claim processing. Each of the 48 hospitals in the NORMET (except KACH) file third party payer claims electronically (N. Abitabilo, Vice President NORMET, personal communication, 17 May 1991).

Filing claims electronically offers MTFs five significant benefits at a relatively small cost. The first benefit is that error rates are usually reduced to below two percent. Second, claims are adjudicated and paid more quickly (from 10 to 30 days faster) (Souders, 1990). Third, it produces a printed explanation of benefits (EOB) which gives a clear and concise description of charges and benefits paid and also serves as a convenient record of payment. Fourth,

the computer performs the arithmetic calculation and also performs some edit checks on the information keyed in by the operator. In this way errors on claim payments are significantly reduced. And fifth, a complete record of the claim recorded on tape is used as input for accounting and statistical work.

Investigating the feasibility of electronic billing can begin by contacting your major insurer or one of the more than 80 electronic billing vendors (See Appendix B for a partial listing of electronic billing vendors). The largest is the National Electronic Information Corporation (NEIC), of Secaucus, New Jersey. The NEIC is a national health care claims clearinghouse. They were founded in 1981 to electronically receive, edit and distribute claims to participating carriers.

The cost of instituting electronic claims processing in a MTF varies with the level of use and scope of service reqired. For example, OmniPro, a division of Empire Blue Cross and Blue Shield, has several electronic claim processing packages. One costs $725.00 per month. This package includes equipment rental and maintenance, training, users manuals, technical support and telephone line charges.

Another package costs $100.00 per month and includes leased software (IBM compatable), manuals, technical support and training. We provide the hardware and telephone line. Either package allows electronic submission of claims, on-line queries, on-line updates, detailed and summary reports, and provider profiles.

In addition to submitting claims electronically, the following recommendations can be used to improve the billing process:

(1) Train all personnel involved in the billing system. Training can begin by obtaining "The Blue Cross Provider Guide for Veterans Administration and Department of Defense Hospitals." This manual is designed to assist billing personnel in completing the UB-82 for Blue Cross and Blue Shield claims. Next, enroll billing personnel in local training seminars to refine old or develop new billing skills. These classes are often sponsored by Medicare, Blue Cross and Blue Shield, or other third party payers (J. Smith, Site Administrator, Southwest Neuropsychiatric Institute, San Antonio, Texas, personal communication, 2 May 1990). All personnel that touch the billing phase must be trained on how to perform their jobs or on how they affect the TPCP. This is especially true

of the medical staff and the medical records specialists since timely completion of the medical record impacts on successful collections from health insurance companies.

(2) Establish a system to monitor billing error rates and reasons for denials and partial payments. Identify the specific data elements most commonly missing or erroneous. Emphasize this information in training programs and concentrate on these errors.

(3) Request that health insurance companies provide your MTF with their billing requirements and special rules (e.g., do they require a provider code or that specific information be entered in a certain data field on the UB-82). Keep this information in a file and develop a profile on each insurance company (e.g., billing address, point of contact, phone numbers).

(4) Visit the patient account managers of local hospitals to review their billing procedures. Many ideas can be borrowed from the successful business offices of neighboring hospitals.

(5) Participate in the local patient account managers association. These groups provide a wealth of up-to-date information on the carriers in the area and serve as a good source for answering specific questions

and keeping current on changes in the insurance industry.

(6) Read. The only way to keep current with the latest developments in third party collections and constantly changing rules and regulations is to read. Suggested journals include: "The Journal of Patient Account Management" published by the American Guild of Patient Account Management (AGPAM), and "The Receivables Report" and "The Health Care Collector" both published by Zimmerman and Associates (Scheaffer, 1989). Get on the mailing list of insurance companies so you receive their bulletins announcing changes to their billing policies.

(7) Audit all bills prior to mailing to verify completeness and accuracy.

Whether claims are submitted electronically or manually, the effectiveness of billing procedures can be measured by the CR, the CPR, and the billing error rate.

Phase Four--Collecting

The successful recovery process culminates in collecting the amount expected from the insurance company. The "amount expected" is defined as the amount of the claim minus copayments and deductibles.

Upon receipt of the claim the insurance company can take one of four actions:

(1) Pay the amount in full.

(2) Deny or return the claim: This occurs primarily when

- there is no record of the patient's enrollment with the company.
- the claim has been submitted incorrectly or incompletly.

(3) Delay the claim. This occurs when the insurance company requires more information (e.g., medical records) to determine liability and payment issues.

(4) Make a partial payment on the claim. This occurs when:

- Deductibles are owed by the patient.
- Copayments are owed by the patient.
- The patient has coinsurance.
- Specific medical procedures are not covered or are considered experimental.
- Specific procedures are not authorized or are unrelated to the admitting diagnosis.
- Outpatient procedures were performed on an inpatient basis without authorization.

- Utilization review requirements were not met.
- Claim submission timeframes were exceeded.
- Policy limitations were met.

When partial payment is received be sure to review the Explanation of Benefits form to verify that penalties are justified, policy deductibles are correct, policy maximums are certified, and medical justifications were approved by your utilization review specialists.

In the event of an unsatisfactory response from a third party payer, DoDI 6010.15 requires sufficent follow-up or collection activities to include telephone contacts, letters, or other appropriate steps to resolve the claim satisfactorily. All claims are to be closed or forwarded from the MTF for formal debt collection within six months from the date the patient is discharged unless a satisfactory resolution is expected within a reasonable timeframe thereafter. The procedures for delinquent claims are described in phase five.

Recommendations for improving collections from insurance companies include the following steps:

(1) Document all follow-up activities.

(2) Assuming that claims are accurately and promptly filed, begin follow-up action within 30 days of submitting the claim (Zimmerman, 1989) The longer a balance remains unpaid, the lower the chances of recovery (Berry, 1990).

(3) Follow-up by phone. Phone calls demand immediate attention. Therefore, they are the best means of following up on an insurance claim. One study found that when contact is made via the telephone, the rate of collected accounts increased to 37% from 16% for non-telephone contact (Nemes, 1990). Be sure to ask when the claim will be processed and paid. Ask if additional information is needed. If so, exactly what is needed and to whom is it to be sent (Zimmerman, 1989). Keep a record of all telephone calls.

(4) Build a profile on each insurance carrier. This profile should include:

- Name and address of each insurance carrier.
- Phone numbers.
- Employers they insure.
- Names of claims managers.
- Explanation of claims processing procedures--including the routing of claims (e.g., are claims initially processed through the employer), average turn

around time, and specific information required (S. Voorhies, Director, Patient Business Services, Bexar County Hospital District, San Antonio Texas, personal communication, 2 May 1990). A typical claim processing flow chart is provided in Appendix C.

(5) Get the patient involved. This suggestion may be more applicable to civilian hospitals since the patient is ultimately responsible for payment of the hospitalization bill. Under the TPCP, the patient has no responsibility or incentive to see that the bill gets paid. However, a cooperative patient may be the best collector since the patient pays the insurance premiums.

(6) Designate one person/section/department to be in charge of collection activities. The idea is to coordinate all collection activities and consolidate all collection experience. Initiate a long-term relationship with the third party payer by developing a rapport with insurance company representatives. Try to speak with the same representative each time you call.

(7) If a claim is denied, examine the reason for denial and request the carrier to reconsider for payment if you believe payment is due.

(8) Train and properly equip those responsible for collection activities. They need ready access to telephones to contact insurers, to AQCESS terminals to retrieve data and generate claims, and to computer terminals and printers to monitor the TPCP and generate reports.

(9) Promote collection activities as a priority. Implement both monetary and non-monetary incentive strategies for the collection staff.

(10) Design the collection process to overcome the lack of an integrated automated system.

The effectiveness of the collection phase is dependent upon the quality of the identification, utilization review, and billing processes. Collections can be measured and monitored by the CR and CPR. In those instances when a carrier does not respond to collection activities, the case should be sent to the Staff Judge Advocate.

Phase Five--Referral of Problem Cases

When collection activities are ineffectual and payable claims become at least six months delinquent, DoDI 6010.15 prescribes the procedures governed by DoD Directive 7045.13, "DoD Credit Management and Debt Collection Program," and DoDI 7045.18, "Collection of

Indebtness Due the United States." Both policies are under the direction of the Comptroller, Department of Defense.

The following situations require referral to the Staff Judge Advocate (SJA):

- The insurer pays the patient rather than the MTF and subsequently refuses to pay the MTF. According to the DoD Office of General Counsel, a third party payer's obligation is not satisfied by paying the patient (Audit Report, 1990).

- The carrier states that it does not pay Federal hospitals or does not pay when the insured has no financial obligation for the cost of care.

- The insurance company does not respond to claims and follow up activities.

- More than one insurer is involved and each denies responsibility for the claim.

- Prior to reporting insurance companies to the State Insurance Commission (e.g., in accordance with New York States' Dispute Resolution process).

Before referring a case to the SJA it is necessary to validate that the claim is proper and delinquent and that all records are accurate and are forwarded with the claim.

Formal referral of cases to the SJA should be an unusual occurrence. Recommendations for improving this process concern legal issues reguarding the rights and responsibilities of third party payers, the MTF and patients. These issues have been addressed by the DoD Office of the General Counsel and are included in DoDI 6010.15.

Monitoring the referral process involves tracking the number of claims referred to the SJA and the results of those referrals.

In summary, the Five Phase Recovery Process is an eclectic compilation of the reimbursement practices and strategies of non-military hospitals. Though based on sound principles, the process, as a whole, has never before been applied to the TPCP by a MTF .

Purpose of the Study

The purpose of this Graduate Management Project was to implement and test the efficacy of the Five Phase Recovery Process at KACH. Implementation was consistent with Deming's principles of Total Quality Management. Results were measured using the key rates: CR, CPR and CGR. The objective was to maximize reimbursements for hospitalizatin from third party payers under the TPCP.

The alternate hypothesis was: Reimbursements under the TPCP are a function of the Five Phase Recovery Process.

The null hypothesis was: Reimbursements under the TPCP are not a function of the Five Phase Recovery Process.

II. METHODS AND PROCEDURES

To investigate reimbursement for hospitalization from third party payers, I contacted major insurers, including commercial insurers, Blue Cross and Blue Shield plans, and HMOs. I also contacted civilian hospitals and the local hospital association. In each organization I located one or more persons knowledgeable about reimbursements and conducted a semistructured interview (either in person or over the telephone).

The results of these interviews were consolidated with the information I gathered from the Veterans Adminstration's Medical Care Cost Recovery Seminar. From this data I developed the Five Phase Recovery Process. The recovery process was implemented at KACH (a 65 bed acute care facility located 50 miles north of New York City) for a six month period which started on 1 October 1990 and ended on 31 March 1991. Claim status was followed through 31 May 1991. Post-study results (the CR, CPR, and CGR as of 31 March 1991) were compared against pre-study data (the CR, CPR, and CGR for FY 1990) to determine effectiveness.

Effectiveness was measured in two ways. First, because I had a large sample, I used the Z test

statistic to test the equality of proportions to determine if the post-study key rates were significantly different from the pre-study key rates. Second, post-study rates had to be at least 30% greater than their pre-study counterparts. I selected 30% after consulting with the Deputy Commander for Administration. It was our opinion that an improvement of this magnitude was more than we could expect to occur naturally as a result of increased collection experience.

I could not compare KACH's CR, CPR, and CGR to those of HSC for several reasons. First, this study accounted for TPCP collections on an accrual basis by month. An effort was made to follow all claims generated during the study from start to resolution. In contrast, HSC tracks TPCP collections on a cash basis. Collections initiated in FY 1990, but not collected until FY 1991, were credited to FY 1991 rather than to FY 1990. This significantly skews collection data and the resulting CR for HSC for the study period.

The impact of the cash basis of accounting is accentuated when the national average for gross days revenue outstanding of 77 days is taken into

consideration (Zimmerman, 1990). This means that the amounts collected for all claims generated on or after 16 July 1990 were probably attrituted to FY 1991. This distortion of the CR could result in a CR greater than 100% since collections could be expected to exceed claims. Since I could not extract the appropriate data from HSC reports, I surmise the pre-study (FY 1990) CR to be artifically low because of FY 1990 collections being attributed to FY 1991 and the FY 1991 study period data to artifically high for the reason stated.

The second reason I could not use HSC's FY 1990 and FY 1991 data was that they do not track the number of claims paid. Therefore, I could not calculate a CPR for the HSC.

The specific methods and procedures for this study are described in the following nine paragraphs:

1. Research. The research for this study actually began in May 1990 and continued through its conclusion (May 1991). It was important to continue research through the entire test period since the TPCP was, and is, still evolving at the DoD, major command, and MTF levels. The research consisted of analyzing relevant policies, procedures, studies, and other literature to determine (1) the intent, guidance and restrictions of

the TPCP, and (2) the characteristics and organization of third party collection processes in various agencies.

2. Interviews and site visits with federal officials. Semi-structured interviews of key DoD officials were conducted throughout the research and study phases. I interviewed key officials in the Office of the Secretary of Defense for Health Affairs; the Office of the Surgeon General, the HSC Patient Administration System and Biostatistics Activity; the HSC Directorate of Resource Management; the HSC Finance and Accounting Division; and Army, Air Force and Navy medical treatment facilities. The purpose of these interviews was to develop a better understanding of the provisions of the TPCP, to stay current on changes to the TPCP, and to determine how the TPCP was implemented at other organizations. I also interviewed extensively and worked closely with officials of the Veterans Administration Medical Care Cost Recovery Program to evaluate, adapt and transfer select procedures to a DoD MTF setting. The VA progam was studied intensively because it is a more established and similar, though broader, version of the TPCP.

3. Interviews and site visits with civilian officials. I conducted personal interviews and site visits with individuals at civilian organizations who were knowledgeable in third party collections. These professionals occupied positions as medical claim reviewers, collection consultants, site administrators, patient account managers, and directors of patient business services. The purpose of these interviews and visits was to evaluate the organizational structure of various finance departments and to investigate alternate billing and collection procedures. An important aspect of this step was networking with the members of the Patient Account Managers Committee of the Northern Metropolitan Hospital Association.

4. Third party payer interviews and site visits. This phase consisted of personal and telephonic interviews with officials of the major third party payers for KACH. These officials occupied positions as directors of health care programs, hospital claims representatives, vice-presidents of reimbursements, and officers of hospital operations liaison committees. The purpose of these interviews was to introduce them to the TPCP, to evaluate their billing and collection requirements, to learn about their training assistance

programs, and to discover other factors which, in their view, aided or impeded the recovery process.

5. Financial ratios. I devised the key financial ratios to assess and compare current and future performance levels. These ratios were designed to be calculated easily (the data they require is readily available at the MTF level) and yet they provide an accurate indication of the overall effectiveness of an MTF's TPCP. In addition, they integrate smoothly into the new TPCP DoDI.

6. Patient interviews. I interviewed patients to get a sense of their knowledge of and receptiveness to the TPCP, to learn about the types and amounts of their insurance coverage, to test their receptiveness to the our newly developed TPCP leaflet (Appendix D), and to get their ideas on how we could improve our TPCP procedures at KACH.

7. Hospital staff marketing and educational program. This campaign was directed towards the hospital staff and consisted of presentations to supervisors at departmental meetings, articles in KACH's weekly bulletin, promoting the results of the TPCP by tracking and announcing the amount of collections at command level meetings, and by just

talking about the TPCP at every opportunity. The goal was to incorporate the TPCP into the KACH's corporate culture.

8. Beneficiary mail survey and educational program. This phase consisted of three steps. The first step was to publish articles in the post newspaper and to offer TPCP presentations to various groups (such as the Retiree Council). The second step consisted of designing, printing, and distributing the TPCP flyer to pharmacy customers, patients visiting the Internal Medicine Clinic, and those being admitted to the hospital. The third step was to conduct a mail survey of 4500 retirees and dependents living in the KACH catchment area. Surveys were mailed to 1500 active duty households and 3000 retiree households. Each survey covered all members of the household. Addresses of families living on West Point or the Stewart Army Subpost were obtained from the West Point Housing Office. Addresses of retirees in the KACH catchment area were obtained from the Retiree Council. The goal of the survey was to (1) educate beneficiaries about the TPCP by providing them with a copy of the TPCP flyer, (2) determine beneficiary awareness of the program, (3) get a sense of their attitude towards the

program, (4) measure the levels and types of insurance coverage, (5) establish a baseline against which we could compare our CGR, (6) backbill the insurance companies of former inpatients who stated they have insurance and for which we did not bill previously, and (7) to enter insurance data into the AQCESS and thereby improve the efficiency of our admissions process.

9. Training program. A training program was conducted for the insurance coordinator, admission clerks, and others involved with the TPCP. The insurance coordinator received training about the history, intent and rules of the TPCP; instruction on identifying and complying with utilization review requirements; guidance on performing billing and collection procedures; and directives about compiling the data for monitoring the TPCP. The admissions and disposition specialists received training on all aspects of the TPCP so they could confidently answer patients' questions. These specialists also attended classes designed to improve their interview skills. The medical staff was informed about their role in utilization review compliance. Finally, all members of the hospital staff were informed of the TPCP. The goal was to make them aware of the program, convey the

importance of the TPCP to the MTFs revenue structure and how it can enhance patient care, and to facilitate their full cooperation.

Reliability and Validity

To ensure the reliability and validity of data used in this study, I collected raw data from source documents rather than from various secondary sources. In addition, I used standardized collection methods and formats.

Ethical Issues

The ethical rights of those people interviewed were preserved by informing them of the purpose of the interview and by stating their right to refuse or stop the interview at any time. All privileged information along with the insurance records of those participating in the TPCP and this study were considered confidential and will not be released. All requests for anonymity were honored.

III. RESULTS

The Key Rates

During the six month study period, 2190 patients were admitted to KACH. Of these, 80 patients (3.65% of those admitted) stated they had health insurance. Of these, 63 had billable policies, resulting in a CGR of 2.88% (63/2190). Of the 63 billable policies, we received payment on 47, resulting in a CPR of 74.60% (47/63).

The 16 outstanding claims (63-47=16) were still being processed two months after the conclusion of the study. Eight of the 17 unbillable policies (80-63=17) were Medicare Supplemental policies. The other unbillable policies were HMO policies which did not cover care provided outside of the HMO system, or the carrier considered the care to be more appropriate for an outpatient setting and would not certify admission.

The value of the 63 claims generated during the study was $121,919.00. Total collections amounted to $79,344.82, resulting in a CR of 65.08% ($79,344.82/$121,919.00).

The mean claim was $1,935.22, with a range of $554.00 to $13,869.00. The mean collection was $1,688.19, with a range of $0.0 to $13,591.

All claims incurred a deductible. The most frequently occurring deductible was $100.00 (46 out of 63 policies). Deductibles ranged in value from $100.00 to $500.00.

The average length of time an account was outstanding was 75 days.

Table 7 provides a comparison of the key rates for the pre-study period (FY 1990) and the post-study period (1 October through 31 March 1991).

The results of the statistical analysis indicate that the post-study key rates are significantly different from the pre-study key rates. I therefore reject the null hypothesis and accept the alternate hypothesis. Reimbursements under the TPCP are a function of the Five Phase Recovery Process. Statistical results are presented in Table 8.

Table 7

COMPARISON OF KACH'S KEY RATES

PRE-STUDY vs POST-STUDY

Rate	Pre-study	Post-Study	DIFFERENCE
CR	40.01%	65.08%	+62.66%
CPR	53.85%	74.60%	+38.53%
CGR	1.31%	2.88%	+120.00%

Note: The pre-study figures are for all of FY 1990. The post-study figures are for the six month period 1 October 1990 through 31 March 1991.

Table 8

STATISTICAL ANALYSIS OF KEY RATES

Rate	Z Value	Significance
CR	-120.91	P_1 does not equal P_2 at any level of significance
CPR	-2.90	Significant at the .004 level.
CGR	-5.26	P_1 does not equal P_2 at any level of significance

Note: P_1 represents the pre-study rate.

P_2 represents the post-study rate.

The TPCP Survey

The TPCP health insurance survey was mailed to 4500 households (1500 active duty and 3000 retiree) in the KACH catchment area. Of these, 1208 were returned with responses, 151 were returned undeliverable, and 1 was returned blank. Of the 1208 responses, 973 respondents stated they had some type of health insurance other than CHAMPUS or Medicare, and 236 stated they had no health insurance.

Of the 973 with health insurance, 157 had not previously been entered into KACH's AQCESS database. Of these 157, 104 had insurance through a primary carrier, and 53 had Medicare or CHAMPUS supplemental policies.

Of the 973 with health insurance, 505 had been entered into the AQCESS but had never been inpatients. Of the 505, 314 had primary health insurance and 192 had supplemental policies.

Of the 973, the remaining 311 (973-157-505=311) had had an inpatient stay subsequent to 1987. Of the 311, 227 had unbillable policies. The policies were not billable because they were supplemental policies, or the policy was not in effect at the time care was rendered. The remaining 84 respondents (311-227=84),

had primary health insurance and were inpatients during FY 1989, FY 1990 or FY 1991.

Of the 84 former inpatients with possible billable policies, 39 had been billed for their stay, and 16 were billed since the survey. The remaining 29 policies (84-39-16=29) were under investigation at the end of the study to verify billability (e.g., to verify if the HMO covers care outside its network, the validity of the policy at the time care was rendered, if dependents were covered by the policy, and if submission time had indeed expired).

Table 9 highlights the results of the survey.

Table 9

KACH TPCP SURVEY SUMMARY

Issue	Number	Percent	Formula
Surveys mailed	4500	----	----
Surveys returned	1208	26.84%	1208/4500
Any health insurance	973	80.55%	973/1208
Billable insurance	398	32.95%	398/1208
Billable/inpatients	84	6.95%	84/1208
Billable cases missed	16	19.05%	16/84

Source: Tabulated from data gathered from the KACH TPCP survey conducted during March 1991.

IV. DISCUSSION

For this discussion, I will provide my personal observations in a chronological order followed by an overview of the key rates and the TPCP survey.

Early in the study it became apparent that KACH lacked the guidance and resources to effectively implement and develop the TPCP. The HSC intently monitored the numbers--the number of claims generated, the dollar amount of claims and the amount of collections--but did not provide advice on how to improve the numbers.

My initial impression of the TPCP at KACH (and other MTFs) was that they were not prepared to deal with insurance companies. Standard operating procedures delineated internal operations to comply with HSC requirements, but lacked a strategy of interaction with third party payers. They did not understand cost containment schemes and they did not appreciate the business viewpoint of commercial insurers. They lacked the wherewithal for effective negotiations and most importantly they lacked experience.

Their system needed the fundamentals upon which to build a TPCP. They needed the basic tools such as (1)

a lexicon of insurance terms (Appendix E) to assist the insurance coordinator understand the technical language of insurance carriers, (2) explicit training or technical manuals describing how to complete and submit UB-82s to meet third party payer specifications, (3) guidance on establishing relationships with third party payers, (4) a system to generate claims according to accepted insurance industry standards, and (5) a system to profile insurance companies and to adequately track the status of claims.

The two major flaws were that they had not researched third party reimbursement procedures and they had not initiated relationships with their major insurers. They generated UB-82s and expected payment. They had not contacted major insurers to introduce them to the TPCP and to solicit their specific billing requirements. This is where I started.

I began by conducting preliminary research on the recovery process. My goal was to develop a sense of the technical aspects of third party reimbursements. Next, I attempted to initiate a relationship with KACH's largest insurer, Empire Blue Cross and Blue Shield. I telephoned them and inquired as to why so many of our claims were denied and why they failed to

respond to our requests for payment. The first thing they asked for was our provider code.

Provider Code

A provider code is used by some insurance companies to identify specific health care facilities as member providers. Award of the provider code indicates the hospital has undergone an institutional review and has been authorized to receive payment from the payor. The assignment of a provider code does not indicate that the MTF has entered into a contract with the carrier. Thus, requesting a provider code does not violate DoDI 6010.15 and it may be the single most important step in developing relations with major insurers.

The primary reason for nonpayment of previously submitted claims to Empire Blue Cross and Blue Shield was that we had not been assigned a provider code. To obtain our provider code we submitted five documents: (1) our request for a provider code, (2) a copy of our most current accreditation from the Joint Commission on Accreditation of Health Care Organizations (JCAHO), (3) a copy of a document authorizing us to be a hospital and provide health care (we submitted the second page of our Table of Distribution and Allowances [TDA] which states our mission and location), (4) a copy of a

document which states the procedures we are allowed to perform (we submitted our Clinical Mission Template which lists the procedures we are authorized to perform), and (5) a federal tax exemption number (we submitted a tax number specific to West Point rather than the Federal Employer Identification Number provided by the HSC because the carrier relates these numbers with address files to identify specific facilities. In addition, insurance carriers use these tax numbers to identify medical facilities on IRS Form 1099 which documents payments to providers).

We received our provider number within six weeks of submitting the required documentation. Prior to being issued a provider code we received payment on a random basis. And when we were reimbursed, the collection rate per claim was at the non-member rate which is approximately 30% of what is billed. After receiving our provider code, our collection rate soared to approximately 80% (payment-in-full minus copayments and deductibles).

Training

A key factor in the success of the TPCP is an experienced staff. KACH did not have a seasoned staff. In fact, billing and collections were an

additional duty of the hospital treasurer. Fortunately, we were able to interview and hire an insurance coordinator just prior to the beginning of the study. Since this one person was to be responsible for all TPCP activities, selection of the right person and proper training were essential to the success of the TPCP.

Factors we considered important in the selection of the insurance coordinator included fluency in business and medical terminology, prior collection experience, degree of aggressiveness, ability to work independent of supervision, ability to work with others (e.g., the hospital staff), creativity, and communication skills.

Once hired, the insurance coordinator and I refined the recovery process to match the KACH environment. We conducted site visits to local health care facilities to observe the organization of their business offices and to learn alternate billing and collection procedures. We welcomed and adopted many of the recommendations aimed at improving the effectiveness of our system. We found ourselves so naive at the business of recovering from third party payers that we did not even know the right questions to ask.

For example, we were not aware of systems already in place which allow rapid access to insurance eligibility information. It was through one of these visits we learned about the Blue Cross and Blue Shield "Fast Check" system. Fast Check is a special service of Empire Blue Cross and Blue Shield which provides a direct linkage between the MTF, via telephone, and the Blue Cross and Blue Shield customer data base. The system provides the MTF with the following eligibility information: effective or cancellation date, waiting period, type of membership, type of contract, number of days of coverage, and benefits information such as mandatory second opinion. This system significantly increased the rate at which we obtained patient eligibility information since it provides immediate access to the data base.

After the insurance coordinator was trained, the marketing and educational campaigns were initiated. These campaigns were followed by the mail survey. Prior to implementing the TPCP full scale we needed to train a group of key players--the admission and disposition specialists. These specialists are responsible for identifying patients with health insurance.

Deming tells us that successful organizations remove barriers to pride of workmanship, train employees to do their jobs correctly and provide the tools to the job. I found that at KACH and other MTFs, the admission and disposition clerks knew little about the TPCP and the importance of their role in the recovery process. They were frustrated with the AQCESS system and with patients who knew little about their insurance coverage. As a result, they were not: (1) persuasive in selling the benefits of the TPCP to patients and thereby eliciting insurance information, (2) understanding and empathetic towards the patient's anxiety to being admitted, (3) professional in their representation of the MTF, (4) personable and able to deal effectively with patients, (5) assertive in expressing their goals and wants to patients, and (6) positive in their attitudes toward requesting TPCP information. Basically, the TPCP was just another Army program in which they did not want to be involved.

To rectify this problem we instituted a training program for the admission clerks. The training was designed to accomplish three goals. First, increase their awareness of the purpose and intent of the TPCP. I felt it was important that these specialists believe

that what they were doing was right and in the best interest of the patient and KACH. Second, emphasize the importance of the role of admissions clerks in the TPCP. Since the recovery process begins with the identification of patients with health insurance their role was critical in recovering funds for KACH. And third, we developed their interview skills by training them to use the following sequence during patient interviews: establish rapport with the patient, explain what the interview will cover and why, obtain the necessary information, respond to questions, and thank the patient for their cooperation.

Currently, the admission and disposition specialists have a more positive, courteous and caring attitude. They realize that their role is crucial in determining the success or failure of the TPCP and that the success or failure of the TPCP directly affects the patient since patient care is enhanced through the purchase of equipment and supplies with TPCP revenue.

The final phase of the education campaign was to train the hospital staff. This consisted of introducing them to the TPCP, identifying and describing their roles, and requesting their cooperation. We considered staff training to be an

important factor in the TPCPs success because we expected daily work routines to be disrupted. For example, utilization review requirements would cause us to consult with various nurses and physicians. This takes away from their clinical time.

Another example concerns insurance claims which have to be submitted in a timely manner. This requires the medical records staff to process the records of billable cases before nonbillable cases. This required open communication and coordination between the insurance coordinator and the medical records staff.

We also asked the medical records staff to inform the insurance coordinator of all third party requests for medical records. The purpose of this request was to verify that we had generated a claim against that case. Usually, we should be releasing the medical records of those patients which we had previously identified as having billable health insurance. That is, unless a patient denied having insurance during admission to the MTF and then subsequently submitted a claim to the insurance company hoping to receive direct payment of benefits. The insurance coordinator could intervene in these cases and intercept the insurance payment.

Once our training program was completed we found that our CGR was increasing monthly. In fact, we generated more claims in the first five months of the study than we did in all of FY 1990 (64 claims versus 62). Since our patient population had not undergone significant change it seemed reasonable to conclude that (1) our identification procedures had improved and (2) we missed billing opportunities in previous fiscal years. Therefore we investigated the feasibility of back billing insurers for care provided to their policy holders in previous years.

Back billing

Our back billing efforts began by submitting or resubmitting claims against the policies of inpatients admitted during FY 1989 and FY 1990 and for whom we had not received payment. Part of this effort included billing for patients with multiple stays. In addition, by cross-referencing the social security numbers of beneficiaries who had health insurance with the social security numbers of their family members we were able to identify and bill for the stay of family members that had not been previously billed.

To determine how far back we could bill, we consulted with Empire Blue Cross and Blue Shield. They

authorized us to submit claims for care dating back to the date of our last JCAHO accreditation, September 1988. No other company provided guidance so we used September 1988 as our cutoff date for all back billing efforts.

We submitted 41 claims for FY 1989. Of the 41, we received payment on 27 for a CPR of 65.85%. Of the 14 we did not receive payment on, the submission time had expired on four, six were erroneous in that the care was not covered by the policy, and four required additional documentation and were pending at the close of this study. The total amount billed was $58,038.00. The total amount collected was $33,765.28, resulting in a CR of 58.18%. The difference, $24,272.72 ($58,038.00-$33,765.28), can be attributed to policy deductibles ($4050 or 6.98% of the total amount billed), care not covered or submission time expired ($15,222.72 or 26.22% of the total amount billed), and claims pending ($5,000.00 or 8.62% of the total amount billed).

We submitted 42 claims for care provided in FY 1990. Of the 42, we received payment on 33, for a CPR or 78.57%. Of the nine for which we were not reimbursed, six were pending at the end of the study,

one was a duplicate claim submitted by mistake, one policy was invalid at the time care was rendered, and one claim was denied because the insurance company considered the care inappropriate for an inpatient setting. The total value of the claims was $60,990.00. The total recovered was $48,302.00 resulting in a CR of 79.20%. The difference, $12,688.00, can be attributed to deductibles ($4,350.00 or 7.13% of the total billed), claims pending ($6,710.00 or 11.00% of the total billed), and duplicate, invalid policy or outpatient care ($1,628.00 or 2.67% of the total billed).

Table 10 presents the results of our back billing efforts. The success of our back billing program may be highlighted by comparing actual TPCP collections made during FYs 1989 and 1990 with the back billing collections of this study. As Table 11 illustrates, the amount collected through back billing exceeded original collections in each fiscal year. In effect, our back billing efforts more than doubled the amount of collections for FYs 1989 and 1990.

The success of our back billing efforts were encouraging and gave us confidence in the Five Phase Recovery Process and our collection system. The

results of the remaining aspects of this study are discussed below in the following four sections:

(1) The claims generation rate.

(2) The claims paid rate.

(3) The collection rate.

(4) The results of the mail survey.

Table 10

RESULTS OF KACH's BACK BILLING PROGRAM

FY	Claims Paid	Amount collected
1989	27	$33,765.28
1990	33	$48,302.00
TOTAL	60	$82,067.28

Note: The average collection per claim was $1,367.79.

Table 11

KACH's COLLECTIONS

BACK BILLING vs INITIAL COLLECTIONS

FY	Initial	Back billing	Total	Difference
1989	$19,665.00	$33,765.28	$53,430.28	+171.70%
1990	$45,997.27	$48,302.00	$94,299.27	+105.01%
TOTAL	$65,662.27	$82,067.28	$147,729.55	+124.98%

Note: The "Difference" column lists the percentage difference between the amount initially collected in the applicable FY and the amount collected by back billing during this study.

Claims Generation Rate

The 120.00% increase in the CGR (Table 7) can be attributed to three factors. One, the training of admission and disposition clerks and the improvements in the methods used to identify patients with health insurance. Two, the beneficiary marketing and education campaign which actually initiates the identification process prior to admission by informing beneficiaries about the TPCP and requesting that they bring their insurance cards with them. And three, increased accuracy in determining the billability of insurance policies.

The training of the admission and disposition specialists was discussed earlier in the paper.

The marketing and education campaign included articles in the post newspaper, distribution of the TPCP leaflet at various locations throughout the hospital and with the TPCP Survey, and appearances at beneficiary meetings.

A new concept currently being initiated is labeling all equipment purchased with TPCP funds. Equipment will be labeled with an eye-catching sticker (Appendix F) which states that the equipment was purchased with TPCP funds. Promotion of the TPCP in this manner is

expected to be extremely effective since both patients and staff will clearly recognize how TPCP revenues enhance health care at KACH.

Purchasing capital equipment with TPCP funds was a change from our previous practice of spending TPCP revenues on pharmaceuticals. The decision to purchase equipment with TPCP funds was made because it (1) served as an effective method of promoting the TPCP and helped instill the TPCP as a normal part of our business routine, (2) verified that TPCP revenue was indeed retained by the MTF and also helped answer the question "What are TPCP funds spent on?", and (3) helped bolster cooperation of both beneficiaries and hospital staff since both stakeholders enjoy the benefits of increased collections.

Perhaps the most important factor affecting the cooperation of both patients and staff is the regulatory provision allowing the collecting MTF to retain TPCP funds. During my interviews, I found patients leery about statements claiming that TPCP collections were under the control of the MTF Commander. Once convinced, they were rather enthusiastic about volunteering insurance information.

This finding was also substantiated by the TPCP survey in which only one of 162 queries was negative.

If TPCP provisions were to change and direct all or part of TPCP collections away from the collecting MTF, I would expect the CGR to decrease in proportion to the amount that is redirected. That is, the greater the redirection of TPCP revenues, the lower the CGR since both patients and the MTF commander (and therefore the hospital staff) have less incentive to pursue third party reimbursements. Changes to this provision of the TPCP would, in my view, nullify the most effective incentive of the TPCP.

Claims Paid Rate

The CPR increased from 53.85% to 74.60% during the study. This 38.53% improvement resulted from (1) revising the methods by which we determine if policies are billable, (2) accurately preparing the UB-82, and (3) aggresively pursuing collections.

The CPR is directly affected by the methods we use to determine if a policy is billable. One method is to develop a profile on each insurance company. Since the TPCP is relatively new, we are still developing our profiles on insurance companies and policies. These profiles are our references collected over time which

help us determine if an individual policy is billable and the special provisions or requirements necessary to file a claim with that company. Third party payer profiles are based on experience which is often gained by trial and error. This leads to a second factor which affects the CPR--the number of erroneous claims generated.

During the study we generated 17 claims erroneously. Of these, three were true errors. The remaining 14 claims fell into a gray area in which we were unable to determine if the policies were in fact billable. When billability could not be determined, our policy was to generate the claim. Of course, generating claims of this type can decrease the CPR since payment is not assured. However, I felt it was better to suffer a lower CPR than risk losing revenue by not submitting a claim.

An example of a gray claim is when we perform a procedure *on an inpatient* basis which the insurance company may or may not consider to be an inpatient procedure. Sometimes our utilization review personnel are able to justify the procedure to the carriers satisfaction and we receive payment. Sometimes the procedure can not be justified as an inpatient

procedure, but by generating the claim we were sometimes reimbursed at the outpatient rate.

The second factor affecting the CPR is correctly preparing the bill. This step involves the admission and disposition clerks obtaining accurate information from the patient, the medical staff completing their entries into the medical record in an accurate and timely manner, the medical records clerks coding the medical record properly and insuring the record is complete, and the insurance coordinator accurately preparing the UB-82. The combination of efforts required to properly prepare a UB-82 illustrates the importance of effective internal communications within the MTF and upholds Deming's principle of breaking down barriers between staff areas.

During the study period, three of the 63 UB-82s had true errors. This resulted in a billing error rate of 4.76% which is significantly below the 20% - 30% rates found by Dingess and Souders for manually generated claims. The low error rate reflects favorably on the entire recovery process at KACH.

The third factor affecting the CPR was the insurance coordinator. The effectiveness of the entire TPCP centers around the insurance coordinator leading

collection efforts, training staff members about their responsibilities towards the TPCP, aggressively pursuing collections from third party payers, educating insurance carriers on their responsibility to comply with the TPCP and, in our case, serving as the liaison with the nursing admissions coordinator to facilitate utilization review compliance.

I expect the insurance coordinator's role to expand with the advent of outpatient billing. In anticipation of expanded duties I have included at Appendix G a draft job description for an insurance coordinator. I have also included at Appendix H a draft job description for a billing clerk who will assist the insurance coordinator.

Collection Rate

The CR for the study period was 65.08%, a 62.66% increase over the FY 1990 CR of 40.01%. The CR was affected by those same factors which affected the CPR with the addition of utilization review. During the study, utilization review was required in 4 cases (5%) and insufficient utilization review decreased collections by 2%. In FY 1990, utilization review was not part of the TPCP at KACH and its absence accounted for 2.8% of the total amount uncollected.

I expect the utilization review function to increase in importance as third party payers strictly assess financial penalties for noncompliance and as they increasingly use utilization review firms to screen admissions. These firms (i.e., Utilization Review, 1-800-622-6252; Review Plus, 1-800-221-2504; and Private Health Care Review, 1-800-624-5052) perform the pre-certification, retrospective review, and case management functions for the third party payers. Their admission criteria are proprietary, stringent and enforced.

The TPCP Survey

The TPCP Survey (Appendix I) and TPCP Leaflet (Appendix D) were mailed to 4500 beneficiaries in the West Point catchment area. The return rate was 26.84% (1208 surveys). Specific survey results are listed in Table 9. Of the respondents, the majority of policy holders with primary care policies were federal employees, state employees, or employees of major corporations in the area (e.g., AT&T and IBM).

The majority of supplemental policies were purchased through (in decreasing order) the American Association of Retired Persons (AARP), The Retired

Officers Association (TROA), and the Association of the United States Army (AUSA).

Approximately 15% of all policy holders were members of a HMO and their care is not covered in our facility except in an emergency situation.

The survey resulted in 162 queries to the insurance coordinator. Inquiries were made either in person, at the KACH Treasurer's Office, or over the telephone. Of the 162, only one comment was negative. The remainder were overwhelmingly in support of the TPCP. A common comment was: "Its about time we did something like this."

We were extremely pleased with the responses on the survey forms. Respondents included many favorable comments and they included copies of their insurance forms and cards, and informational brochures about their insurance plans and coverage.

Our survey indicated that 32.95% of the respondents have health insurance. This means that KACH has the potential of generating an insurance claim for approximately one out of every three inpatients and our CGR could get as high as 32.95%. That could only happen if all those with health insurance use our facility for their inpatient care. However, the survey

also indicates that of those with health insurance coverage, only 6.95% actually use KACH.

This variance suggests that of those with health insurance, only one out of five (6.95 out of 32.95) choose to use KACH for their inpatient needs. The factors which determine MTF use are outside the scope of this study, but they should prove to be interesting subjects for future studies.

We made several mistakes in designing and administering the survey. First, we did not specifically request that all recipients reply, regardless of insurance coverage. This error was brought to our attention by people without insurance who did not respond to the survey. This mistake introduced bias since an unknown number of recipients without insurance coverage did not respond.

The second mistake was that we used a nonrandom rather than a random sampling technique. Therefore, the results must be considered in the context that certain populations were not polled (e.g., active duty families living off post) and we did not get a representative sample of the beneficiary population. Self selection is also a factor since those who responded (or did not respond) did so for their own

reasons (perhaps they wanted to hide the fact that they have health insurance).

In light of these weaknesses, the sample size was sufficiently large to lend power to the results and to serve as a start point. In addition, the survey does provide an indication of insurance coverage and MTF use in the KACH catchment area.

V. CONCLUSIONS AND RECOMMENDATIONS

This study has helped to clarify the procedures inherent in reimbursement for hospitalization and it indicates that the Five Phase Recovery Process is an effective method of increasing collections under the TPCP.

Since there is not a long history of data I can not say if the study period was of sufficient length to be representative of the results other MTF can expect. To increase the power of this study I recommend a repeat study.

The expense of establishing a TPCP is insignificant compared to the payoff. In our case, a $26,222.75 investment (including salary, postage and printing fees, training expenses, telephone charges and a computer system) netted $161,412 in revenue during the study period (the first two quarters of FY 1991). Appendix J lists the specific costs for the first three quarters of FY 1991.

The most important factor in effectively implementing the Five Phase Recovery Process is staffing. A seasoned staff is the key to success. Based on this study, I estimate that it takes two months for the admission clerks to become proficient at

identifying patients with health insurance. And, it takes about six months for the insurance coordinator to become effective in billing and collecting from third party payers.

Training and networking must be an integral component of the TPCP. Insurance companies constantly search for and pick up on cost-effective solutions at one hospital and implement it throughout their system. Then other providers are forced to accept the change. An effective training program will help you deal with changing reimbursement practices. Networking will help you anticipate changes and resolve them in your best interest.

A prime objective of the MTF should be to develop a long-term relationship with their third party payers. The goal is to form a mutually supporting relationship between the MTF and insurers. Facilities with the most successful TPCPs will be able to work with third party regulations as well as third party administrators.

I recommend that HSC initiate a strategic alliance among its major insurers. The concept is to work together with the belief by all parties that that will result in more effective and efficient performance for providers, payers, and patients. Negotiations could

begin by studying methods of streamlining the billing process.

I recommend that the HSC adopt the key rates to measure the performance of the TPCP. The HSC can not effectively manage the TPCP when they cannot accurately measure it. This would require changing to an accrual basis of accounting from the cash basis currently used. It will also require MTFs to track and report to HSC the number of claims paid.

Patients must be introduced to the TPCP prior to their arrival to the MTF. My early interviews with Patient Administration Division officers led me to believe that patients would resist involvement in the TPCP. This was our experience in the early phase of the study. Now we have patients volunteering insurance information. The difference between then and now is the TPCP leaflet and our aggressive patient education campaign (including the TPCP survey). Our program prepares patients for the admissions process by informing them of what we are doing, why we are doing it, and how we are going to do it.

The study also included the TPCP survey which provides some evidence to suggest that the majority of

beneficiaries with private health insurance do not use the MTF for their inpatient needs.

This finding may be important for MTFs involved in the Gateway to Care program. For example, do these facilities want to market to beneficiaries with health insurance, enroll them in Gateway, and thereby place an additional burden on the MTF? Or, is it to the MTF's advantage to enroll these beneficiaries in Gateway and receive capitated reimbursements from HSC and also receive from the patient's insurance company the third party reimbursement when care is rendered? Each MTF must perform its own cost/benefit analysis and make this decision for themselves.

I recommend that every MTF conduct a TPCP survey. The purpose is to (1) gather insurance information from beneficiaries and thereby increase the efficiency of the admissions process, (2) serves as a tool for estimating the MTF's maximum CGR, (3) determine the number of beneficiaries with health insurance who actually use the MTF, and (4) to initiate an aggresive back billing campaign.

I recommend that MTFs immediately investigate their potential for processing claims electronically. I expect that third party payers will soon demand

electronic claims processing (this has already occurred in New York State). In addition, electronic processing of claims will be required to efficiently process the volume of claims when MTFs start billing for outpatient services. Adopting electronic billing will increase cash flow by decreasing turnaround time, decrease billing errors with its editing features, save personnel costs by increasing efficiency, and prepare MTFs for industrywide standardization of electronic transactions.

This study has analyzed the efficacy of the Five Phase Recovery Process in maximizing reimbursements for hospitalization under the TPCP. The Five Phase Recovery Process delineates in a universally applicable fashion, steps which commanders can implement immediately to improve their recovery system, increase revenue, and thereby enhance health care to its beneficiaries.

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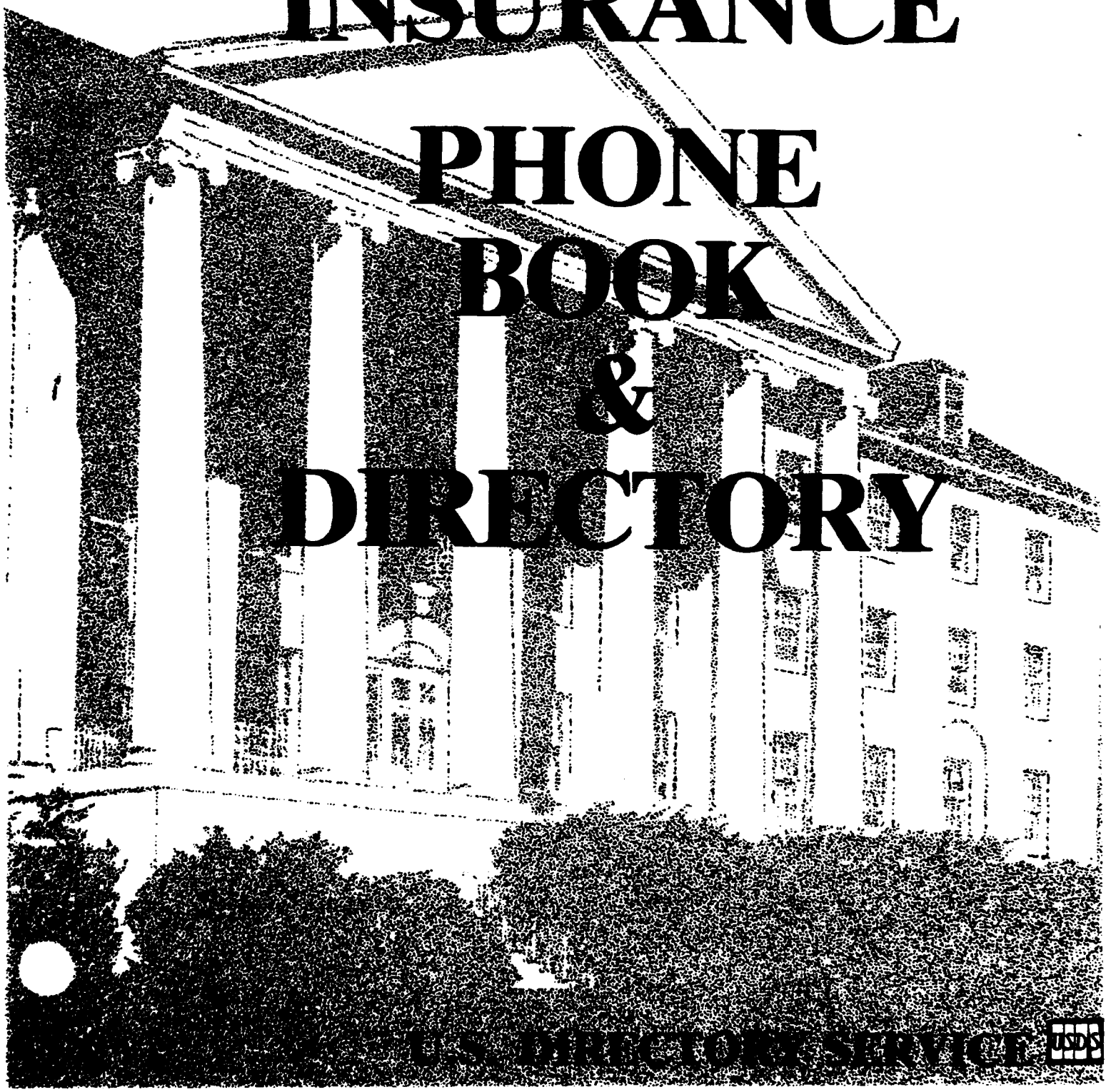
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APPENDIX A

INSURANCE PHONE BOOK & DIRECTORY

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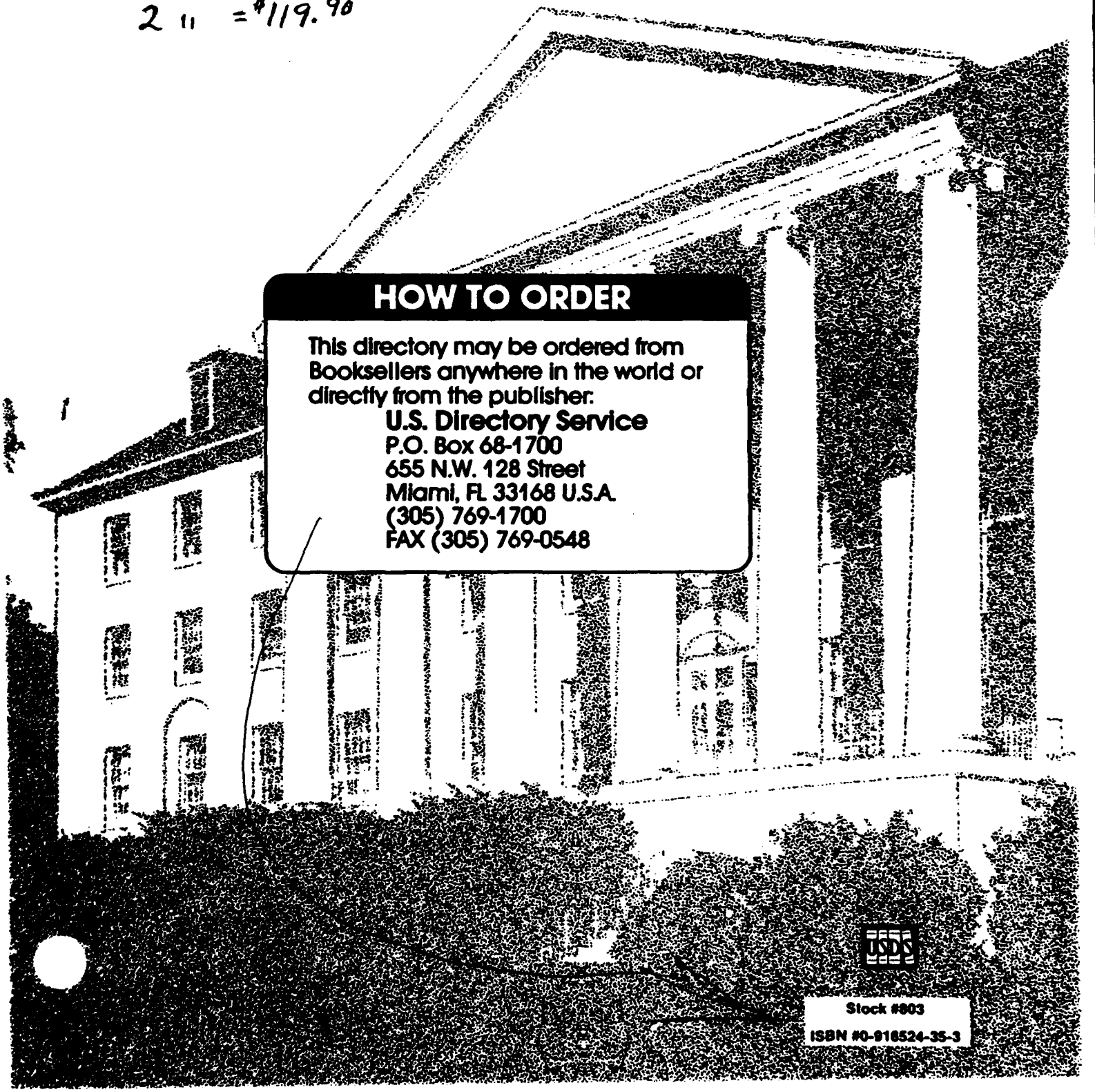


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APPENDIX B

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PARTIAL LISTING OF ELECTRONIC BILLING VENDORS

NATIONAL

ACM, Inc	Riverside, CA	800-747-2149
APS Medical Billing	Toledo, OH	419-866-1804
Advanced Card Sciences, Inc.	Atlanta, GA	404-454-0110
CIS Technologies	Tulsa, OK	918-496-2451
Claims By Computer	Fort Worth, TX	817-735-1221
Companion Technologies	Columbia, SC	800-344-5714
Computermart Medical Services	Rex, GA	404-478-5681
Conceptual Systems Corporation	Cleveland, OH	216-449-0600
Cycare Systems, Inc.	Phoenix, AZ	602-952-5300
Electronic Tabulating Service, Inc.	Atlanta, GA	404-688-8411
Express Claim Processing	Baton Rouge, LA	504-924-3545
Fiscal Information, Inc.	Daytona Beach, FL	904-253-6222
GTE	Rockville, MD	301-340-4771
Health Management Systems, Inc.	New York, NY	212-685-4545
IDX Corporation	Boston, MA	617-566-6800
INCOMRx Systems	Peabody, MA	617-535-4333
Medical Data Systems	Twinsburg, OH	800-521-4528
Medical Electronic Data Exchange	Oklahoma City, Ok	800-999-4239
Medical Practice Management, Inc.	Richmond, VA	804-320-7009
Medical Software Solutions, Ltd.	Naperville, IL	312-717-8848
MEDS AMERICA, Inc.	Houston, TX	713-523-6337
MicroBilt Corporation	Atlanta, GA	404-955-0313
Multi Medical Management	Greenville, TX	214-454-2211
National Computer Claim Services, Inc.	Palm Harbor, FL	800-822-2850
National Medical Computer Services	San Diego, CA	619-566-5800
National Teledata Corporation	Norwell, MA	617-871-3034
Physicians' Software	Deer Park, NY	516-586-3397
RK/Caremaster	Dallas, TX	214-528-7700
Safier Program Systems, Inc.	San Mateo, CA	415-570-7578
SMS	Malvern, PA	215-296-6300
Sophisticated Software, Inc.	Largo, FL	800-346-3495
TeleClaim, Inc.	Birmingham, AL	205-870-0554
Touche Ross and Company	Newark, NJ	201-622-7100
United HealthCare, Inc.	Baltimore, MD	301-265-6033
Value Medical Service	Oklahoma City, OK	405-840-9334
Wismer Martin	Mead, WA	509-466-0396

NORTHEAST

Automated Medical Systems, Inc.	Brookline, MA	617-739-3115
Central Billing Services, Inc.	Glen Burnie, MD	301-760-1162
Healthcare Data Systems	Dewitt, NY	800-950-7111
LifeCard International, Inc.	Towson, MD	301-494-4800
Medical Processing Center	Macedonia, OH	216-468-0115
National Medical Financial Services, Inc.	Orange, NJ	201-678-1517
Quadax, Inc.	Cleveland, OH	216-777-6300
Vanguard Physician Services	Glens Falls, NY	518-793-9101

MID-ATLANTIC

CBSI	Rockville, Md	301-770-2292
Central Billing Services, Inc.	Glen Burnie, MD	301-760-1162
Medical Claims Management	Demarest, NJ	201-784-0612
Medical Management Sciences	Richmond, VA	804-320-7925
Vanguard Physician Services	Glens Falls, NY	518-793-9101

SOUTHEAST

Advanced Medical Data Systems	Kansas City, MO	816-454-8941
BC/BS of Georgia/The Network Group	Columbus, GA	404-649-3100
BC/BS of Tennessee	Chattanooga, TN	615-755-5717
Central Billing Services, Inc.	Glen Burnie, MD	301-760-1162
CompuSystems, Inc.	Columbia, SC	803-736-0673
Computer Services Corporation	Birmingham, AL	205-320-6900
Consultants Service, Inc.	Miami, FL	305-596-6025
Health Communications Services	Glen Allen, VA	804-965-6100
Health Data Network	Louisville, KY	
Health Management Services	Miami, FL	305-652-4913
Medical Payment Systems, Inc.	Westlake, OH	800-334-2644
Quadax, Inc.	Cleveland, OH	216-777-6300
Quality Medical System, Inc.	Miami, FL	305-665-6294
Telecare Reimbursement Systems, Inc.	Denville, NJ	201-627-7094

MIDWEST

ACB Healthcare Financial Services	Glen Ellyn, IL	312-629-1528
Advanced Data Management, Inc.	West Chicago, IL	312-834-1161
Advanced Medical Data Systems	Kansas City, MO	816-454-8941
Baylor College of Medicine Urology	Houston, TX	713-799-4555
BC/BS of Kansas	Topeka, KS	913-291-7792
BC/BS of Minnesota	St. Paul, MN	612-456-8226
Computing Services, Inc.	Lenexa, KS	913-888-1050
Datashare Corporation	Mayfield Heights, OH	216-473-6590
Delta Financial Services, Inc.	Houston, TX	713-953-0636
Health Data Network	Louisville, KY	
Indiana University Diagnostic Assoc.	Indianapolis, IN	317-274-3958
3PM/McKesson	Livonia, MI	313-523-9646
Med-Data, Inc.	Seattle, WA	206-343-5656
Medical Billing Management Services	Palo Alto, CA	800-448-1333
Medical Payment Systems, Inc.	Westlake, OH	800-334-2644
Medical Processing Center	Macedonia, OH	216-468-0115
Mediquest	Kansas City, MO	816-523-0100
Med-Systems Management, Inc.	Dayton, OH	513-898-7172
Physician Practice Management, Inc.	Indianapolis, IN	317-248-0357
Physicians' Service Center, Inc.	Englewood, CO	708-960-9222
Procare/EBS Systems, Inc.	Englewood, CO	303-773-1933
Professional Receivables Control, Inc.	Canton, OH	216-493-9004
Quadax, Inc.	Cleveland, OH	216-777-6300
Scientific Data Management, Inc.	St. Clair Shores, MI	800-538-6339

SOUTHWEST

ACCOM Financial Services	Hurst, TX	817-268-1717
Advanced Medical Data Systems	Kansas City, MO	816-454-8941
Claims Express of America	Tulsa, OK	918-747-3225
CSA Provider Services	Tempe, AZ	602-864-0611
Electro-Claim & Associates	Houston, TX	713-741-6849
Holmes & Shaw, Inc.	San Antonio, TX	512-494-6184
Insurance Filing Service, Inc.	Wichita Falls, TX	817-761-1203
Integrated Medical Systems	Fountain Valley, CA	714-964-9965
Keplinger Computer Systems	Houston, TX	713-840-8510
Med-Data, Inc.	Seattle, WA	206-343-5656
Medica Financial Corp.	Houston, TX	713-785-8084
Medical Accounts Management, Inc.	Baytown, TX	713-427-1339
Medical Billing Management Services	Palo Alto, CA	800-448-1333
Mednet, Inc.	Fort Worth, TX	817-293-2000
Med-Systems Management, Inc.	Dayton, OH	513-898-7172
Micro Consulting, Inc.	Oklahoma City, OK	405-528-8133
Mid-America Computing, Inc.	Overland Park, KS	
North American Health Insurance Coord.	Houston, TX	800-223-6688
Procare/EBS Systems, Inc.	Englewood, CO	303-773-1933
Pro-Claim	Houston, TX	713-939-1000
Spring Group	Norwalk, CA	213-868-9779

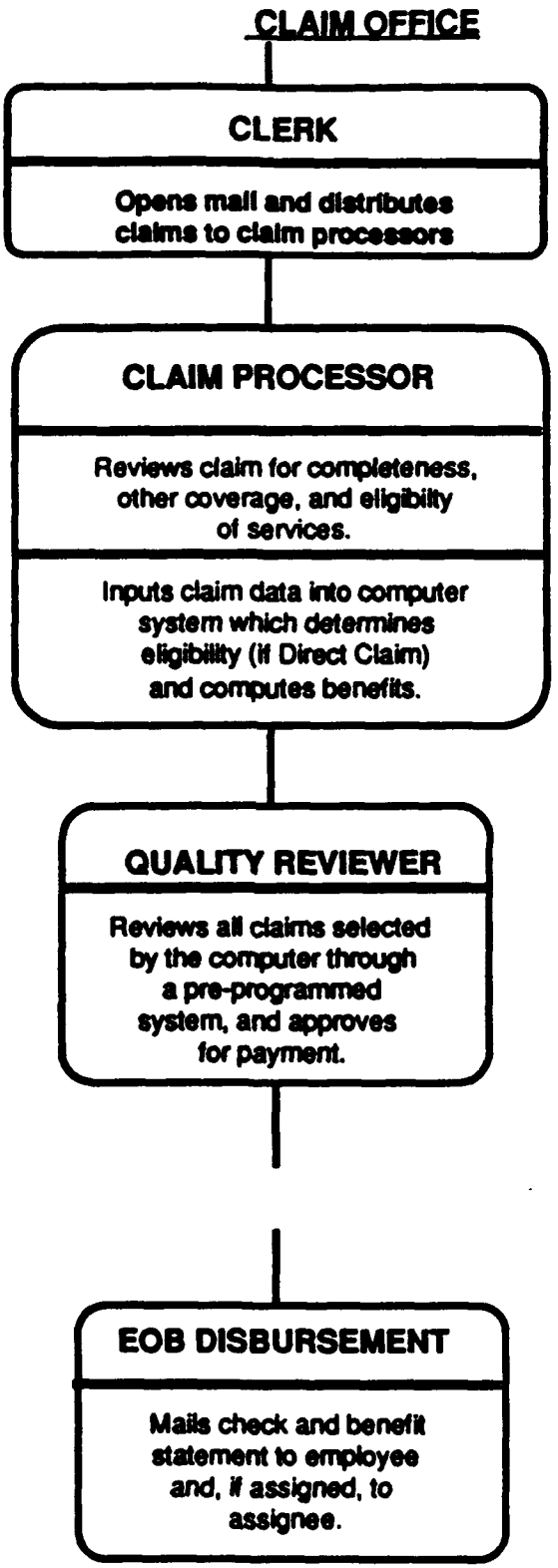
WEST

Arizona Heart Institute	Phoenix, AZ	602-995-1000
Comprehensive Care Corp.	Irvine, CA	714-253-7352
DLWD Medical Management	Denver, CO	303-297-8428
Emits, Inc.	West Covina, CA	818-967-8036
Endocrine Metabolic Center	Oakland, CA	415-835-4940
Integrated Medical Systems	Fountain Valley, CA	714-964-9965
MEDAC, Inc.	Harbor City, CA	213-539-9666
Med-Data, Inc.	Seattle, WA	206-343-5656
Medical Billing Management Services	Palo Alto, CA	800-448-1333
Medical Payment Systems, Inc.	Westlake, OH	800-334-2644
Medical Service Corp.	Spokane, WA	509-536-4788
Medicom Corp.	San Francisco, CA	415-956-0382
Nelson Resource Group	Newport Beach, CA	714-660-0169
Quality Medical Adjudication, Inc.	Sacramento, CA	916-361-5400
RIS, Inc.	Tuscon, AZ	602-881-7511
Spring Group	Norwalk, CA	213-868-9779
Stratford Healthcare Systems, Inc.	Burlingame, CA	415-692-7970

APPENDIX C

CLAIM PROCESSING FLOW CHART

CLAIM PROCESSING FLOW CHART



APPENDIX D

TPCP LEAFLET

HELP KELLER ARMY COMMUNITY HOSPITAL TO HELP YOU

ARE YOU A RETIREE OR DEPENDENT?

KELLER ARMY COMMUNITY HOSPITAL

NEEDS TO KNOW ABOUT

YOUR HEALTH INSURANCE

IT'S THE LAW !

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) established the Third Party Collection Program. Under this program Military Medical Treatment Facilities are authorized and obligated to bill health insurance carriers (like Blue Cross or Prudential) for the cost of medical care furnished to retirees and dependents who are covered by health insurance policies. Keller Army Community Hospital (KACH) must comply with this law, and we need your help to make this program successful.

DO YOU HAVE HEALTH INSURANCE ?

You will be asked that question when you are admitted to KACH. Under the law, we are required to determine if the government's cost of your care can be recovered from companies providing group and individual health insurance. If you are covered by a health insurance policy, or are a member of an HMO (such as POMCO, or GHI) we will need your insurance information.

YOU WILL NOT BE BILLED BY KACH OR YOUR INSURANCE COMPANY

The obligation to pay medical care costs applies only to the insurance carrier. You will not be sent a bill for amounts not covered by the carrier. KACH is entitled to obtain the same benefits for its health care services that any other medical care provider would receive. Your insurance company will pay benefits directly to us and you will not be billed for any uncollected charges.

INSURANCE INFORMATION IS ALWAYS NEEDED

In most cases, KACH is no different than other health care providers who need insurance information. To collect benefits covered by your health insurance, we must have the information that appears on your health insurance identification card. Please have this card with you every time you come to the hospital. Your cooperation will be greatly appreciated.

SOME OF THE MOST FREQUENT QUESTIONS ASKED ABOUT HEALTH INSURANCE

HEALTH CARE IS ONE OF MY SERVICE BENEFITS. WHY DOES KELLER ARMY COMMUNITY HOSPITAL HAVE TO BILL MY INSURANCE COMPANY?

Quality health care is very expensive, and costs are rising at an alarming rate. Your health care is paid for by your federal tax dollars. The law requires KACH to recover these costs if they are covered by insurance.

WILL I STILL HAVE TO PAY THE SUBSISTENCE CHARGE FOR INPATIENT STAYS?

Yes. The subsistence charge must still be paid. You may pay it before you leave the hospital at the Treasury Office on the first floor.

WHAT EFFECT WILL THIS HAVE ON MY HEALTH INSURANCE?

Health insurance is intended to cover your needs for medical services listed in your policy and the premiums you pay are for those services. Since you are using that policy to allow KACH to recover the cost of providing you with health care, the insurance is being used exactly as it is intended. Generally speaking, it should not significantly affect your rates.

IF THE FULL COST OF CARE IS NOT RECOVERED, WILL I GET A BILL FROM KACH OR MY INSURANCE COMPANY?

NO. You will not be billed for any costs that we cannot recover. Federal tax dollars will cover the rest.

WHEN I RECEIVE CARE FROM KACH, WILL I NEED TO PAY MY POLICY DEDUCTIBLE?

NO. KACH will absorb this deductible. This may even satisfy your policy deductible if you later seek private medical care.

WHERE DOES THE MONEY GO?

Payments from your insurance company for your health care go into the KACH Treasury. The money that is collected is used to enhance the quality of care at Keller Army Community Hospital.

WHAT WILL I RECEIVE FROM THE INSURANCE COMPANY?

You will receive an Explanation of Benefits Form from your insurance company telling you how much was paid to us, and what deductibles or copayments were subtracted from the claim we filed. This is not a bill. You are not responsible for copayments or deductibles not paid to us even if they appear on your Explanation of Benefits Form.

FOR MORE INFORMATION CALL THE INSURANCE COORDINATOR AT 914-938-3162

APPENDIX E

GLOSSARY OF HEALTH CARE TERMS



GLOSSARY OF HEALTH CARE TERMS



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First Edition, 1988



Glossary of Health Care Terms

As you are undoubtedly aware, the health care industry makes extensive use of technical terms. And because of the nature of the environment and marketplace, the jargon continually evolves.

This glossary of terms is intended to provide a starting point for ongoing refinement and expansion. The best source for such corrections and updates comes from you, the collective readers. So please help contribute to future editions of this material. If you can suggest improvements in definitions or have additional terms with their definitions to offer, please submit them to:

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The information in this first edition was collected from a variety of sources which are acknowledged below:

"Let's Talk About Health Insurance"
American Medical Association

"Marketing Representative's Guide to National Accounts"
Blue Cross and Blue Shield of Alabama

The Health Insurance Answer Book
Institute for Management

"Health Care Service Corporation Corporate Glossary"
Blue Cross and Blue Shield of Illinois

"A Glossary of Health Care Terms"
CHC Program, Blue Cross and Blue Shield Association

"Source Book of Health Insurance Data"
Health Insurance Association of America

"How to Speak Blue Cross/Blue Shield"
Blue Cross and Blue Shield of New Mexico

A

Abuse: Improper or excessive use of program benefits or services by providers or consumers. Abuse can occur, intentionally or unintentionally, when services are used which are excessive or unnecessary; which are not the appropriate treatment for the patient's condition; when cheaper treatment would be as effective; or when billing or charging does not conform to requirements. It should be distinguished from fraud, in which deliberate deceit is used by providers or consumers to obtain payment for services which were not actually delivered or received, or to claim program eligibility. Abuse is not necessarily either intentional or illegal.

Accelerated Payment: Temporary partial advance of funds to providers due to temporary delays in payments on claims.

Access: An individual's (or group's) ability to obtain medical care. Access has geographic, financial, social, ethnic and psychic components and is difficult to measure operationally. Many government health programs have as their goal improving access to care for specific groups or equity of access in the whole population. Access is also a function of the availability of health services, and their acceptability.

Accident: An event or occurrence which is unforeseen and unintended.

Accidental Death and Dismemberment: One of the four major components of health insurance coverage employers provide their employees. The others are: life, disability, and medical insurance. AD&D provides coverage for death or dismemberment resulting directly from accidental causes.

Accreditation: The process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined standards. The recognition is called accreditation. Similar assessment of individuals is called certification. Accreditation is usually given by a private organization created for the purpose of assuring the public of the quality of the accredited (such as the Joint Commission on Accreditation of Hospitals). In some situations public governments recognize accreditation as the basis of licensure. Public or private payment programs often require accreditation as a condition of payment for covered services.

Accommodation: Type of hospital room; e.g., private, semiprivate, ward, etc.

Accumulation Period: A specified period of time, such as 90 days, during which the insured person must incur eligible medical expenses at least equal to the deductible amount in order to establish a benefit period under a major medical expense or comprehensive medical expense policy.

Actual Charge: The amount a physician or other practitioner actually bills a patient for a particular medical service or procedure. The actual charge may differ from the customary, prevailing, and/or reasonable charges under insurance programs.

Actuary: A person trained in statistics, accounting, and mathematics who determines policy rates, reserves, and dividends by deciding what assumptions should be made with respect to each of the risk factors involved (such as the frequency of occurrence of the peril, the average benefit that will be payable, the rate of investment earnings, if any, expenses, and persistency rates), and who endeavors to secure valid statistics on which to base these assumptions.

Acute Care: A level of care that can be rendered only in a hospital.

Acute Disease: A disease which is characterized by a single episode of fairly short duration from which the patient returns to his normal or previous state and level of activity. Acute diseases are distinguished from chronic diseases.

Additions (Adds): New subscriber contracts or members.

Adjudication: Determination of payment allowance on a claim.

Admission Certification: A form of medical care review in which an assessment is made of the medical necessity of a patient's admission to a hospital or other inpatient institution. Admission certification seeks to assure that patients requiring a hospital level of care, and only such patients, are admitted to the hospital. Lengths of stay appropriate for the patient's admitting diagnosis are usually assigned and certified, and payment by any program requiring certification for the assigned stay is assured. Certification can be done before (preadmission) or shortly after (concurrent) admission.

Administrative Services Only (ASO): An arrangement under which an insurance carrier or an independent organization will, for a fee, handle the administration of claims, benefits and other administrative functions for a self-insured group.

Admitting Physician: The physician responsible for admission of a patient to a hospital or other inpatient health facility. Some facilities have all admitting decisions made by a single physician (typically a rotating responsibility) called an admitting physician.

Adverse Selection: Disproportionate insurance of risks who are more prone to suffer loss or make claims than the average risk. It may result from the tendency for poorer risks or less desirable insureds (sick people) to seek or continue insurance to a greater extent than do better risks (healthy people), or from the tendency for the insured to take advantage of favorable options in insurance contracts.

Affiliated Hospital: One which is affiliated in some degree with another health program, usually a medical school.

Age Discrimination in Employment Act of 1967: As amended in 1978, ADEA requires employers with 200 or more employees to offer older active employees under age 70 who are eligible for Medicare (and their spouses if they are also under age 70) the same health insurance coverage that is provided to younger employees.

Age Limits: Stipulated minimum and maximum ages below and above which the company will not accept applications or may not renew policies.

Agent: An insurance company representative licensed by the state who solicits, negotiates, or effects contracts of insurance, and provides service to the policyholder for the insurer.

Aggregate: When the combined out-of-pocket expenses among all family members totals the pre-determined aggregate out-of-pocket limit.

Aging Factor: The maximum time expectation (determined by the carrier) for claim processing both in-house and in-status.

Allocated Benefits: Benefits for which the maximum amount payable for specific services is itemized in the contract.

Allowable Charge: The amount of payment an insurance company *allows* for a covered service, which may be less than the *actual charge* by the physician or hospital. The difference between the physician's actual charge and the insurer's allowable charge will depend on the terms of the insurance contract, how the allowable charge is determined, how often it is updated, and other factors.

All-Inclusive Rate: Payment rates to providers that include ancillary services plus routine services.

Allied-Health Personnel: Specially trained health workers other than physicians, dentists, podiatrists, and nurses. The term has no constant or agreed upon meaning: sometimes meaning all health workers who perform tasks which must otherwise be performed by a physician; and sometimes referring to health workers who do not usually engage in independent practice.

Allocated-Benefit Provision: A provision in an insurance policy under which payment for certain benefits (such as miscellaneous hospital and medical services like X-rays, dressings and drugs) will be made at a rate for each specified (scheduled) in the provision. Usually there is also a maximum that will be paid for all such expenses. An allocated benefit is one which is subject to a provision. In an allocated benefit provision no specification is given of how much will be paid for each type of service although the provision sets a maximum payable for all listed services.

Allowable Charge: The maximum fee that a third party will use in reimbursing a provider for a given service. An allowable charge may not be the same as either a reasonable, customary or prevailing charge.

Allowable Costs: Items or elements of an institution's costs which are reimbursable under a payment formula. Allowable costs may exclude, for example, uncovered services, luxury accommodations, costs which are not reasonable, expenditures which are unnecessary in the delivery of health services to persons covered under the program.

Alternate Delivery Systems (ADS): A method of providing a comprehensive health care program to subscribers other than the traditional fee-for-service method (e.g., HMOs, PPOs).

Ambulatory Care: Health services which are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients.

Amendment: A document changing the provisions of an insurance policy signed jointly by the insurance company officer and the policyholder or authorized representative.

Application: A statement of facts requested by the company on the basis of which the company decides whether or not to issue a policy. This then becomes part of the health insurance contract when the policy is issued.

American Hospital Association (AHA): A voluntary association of hospitals organized for the purpose of helping hospitals provide better patient care.

American Medical Association (AMA): A public service organization dedicated to the advancement of science and medicine and betterment of the public health and welfare.

Ancillary Services: Hospital services other than room and board, and professional services. They may include X-ray, drug, laboratory or other services.

Anniversary Date: Date on which an account will be re-enrolled each year subsequent to its initial enrollment.

Application Card: A card completed by a member for one of the following reasons: to initiate membership; to change from individual to family contract; to change from family to individual contract; to change name; to add a dependent; or to correct information on subscriber's file.

Assigned Risk: A risk which underwriters do not care to insure (such as a person with hypertension seeking health insurance) but which, because of State law or otherwise, must be insured. Insuring assigned risks is usually handled through a group of insurers (such as all companies licensed to issue health insurance in the State) and individual assigned risks are assigned to the companies in turn or in proportion to their share of the State's total health insurance business. Assignment of risks is common in casualty insurance and less common in health insurance.

Assignment: Payment for covered services goes directly to the physician.

Association Group: A group formed from members of a trade or a professional association for group insurance under one master health insurance contract.

At Risk: The state of being subject to some uncertain loss or difficulty. In the financial sense, this refers to an individual, organization or insurance company assuming the chance of loss — through running the risk of having to provide or pay for more services than paid for through premiums. A second use of the term relates to the special vulnerability of certain populations to certain diseases or conditions; e.g., workers in coal mines at risk for black lung disease.

B

Bad Debts: The amount of income lost because of failure of patients to pay amounts owed. Some cost-based reimbursement programs reimburse certain bad debts.

Beneficiary: A person who is eligible to receive benefits from an insurance policy.

Benefit: Payments provided for covered services, under the terms of the policy. The benefits may be paid to the insured or on his behalf to others.

Benefit Days: Number of days for which the insurance carrier will make payment within a benefit period.

Benefit Period: The period of time for which payments for benefits covered by an insurance policy are available.

Billing: An itemized account of subscriber dues owed to the Plan by a group or subscriber; an itemized account of services rendered by a physician or supplier.

Binding Receipt: A receipt given for a premium payment accompanying the application for insurance. If the policy is approved, this binds the company to make the policy effective from the date of the receipt.

Blanket Coverage: Benefits under a family subscriber contract to dependents whose names and ages are not listed on the application form.

Blanket Medical Expense: A provision which entitles the insured person to collect up to a maximum established in the policy for all hospital and medical expenses incurred, without any limitations on individual types of medical expenses.

Business Insurance: A policy which provides coverage of benefits to a business as contrasted to an individual. It is issued to indemnify a business for the loss of services of a key employee or a partner who becomes disabled.

C

Capitation: A method of payment for health services in which an individual or institutional provider is paid a fixed, per capita amount for each person served without regard to the actual number or nature of services provided to each person. Capitation is characteristic of health maintenance organizations.

Case: A covered instance of sickness or injury.

Cases Incurred: The claims for which a Plan becomes liable during a given accounting period.

Cases Paid: Claims approved and paid by a Plan during a given accounting period.

Cases Payable: Accounts payable for services to subscribers for which statements have been received by a Plan.

Cases Reported But Undischarged: An estimated liability for claims known to a Plan but for which no statement has been received by the Plan.

Cases Unreported: An estimated liability for cases not reported to a Plan for which liability is presumed to exist.

Catastrophic Coverage/Illness: Benefits included in certain insurance plans to protect insured individuals from extraordinary expense incurred as a result of serious or prolonged illnesses or injuries. Many plans with catastrophic coverage also place maximum ceilings on how much the plan will pay for insured individuals' covered expenses during their lifetimes.

Census: An enumeration of items; members, patients, class of risk, coverage classification, type of contract, etc.

Central Certification: A method of certifying subscriber's eligibility and available benefits from a centralized master file.

Certificate: The document expressing terms and benefits to which the subscriber is entitled.

Certificate-of-Need: A certificate issued by a governmental body to an individual or organization proposing to construct or modify a health facility, or offer a new or different health service, which recognizes that such facility or service when available will be needed by those for whom it is intended.

Charge-Based Reimbursement: Payments to institutional providers for the actual costs incurred for covered services plus reimbursement of a profit factor, bad debts and cost of charity cases.

Charges: Prices assigned to units of medical service, such as a visit to a physician or a day in a hospital. Charges for services may not be related to the actual costs of providing the services. Further, the methods by which charges are related to costs vary substantially from service to service and institution to institution. Different third-party payers may require use of different methods of determining either charges or costs.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS): A program administered by the Department of Defense, which pays for care delivered by civilian health providers to retired members, and dependents of active and retired members, of the seven uniformed services of the United States (Army, Navy, Air Force, Marine Corps, Commissioned Corps, Commissioned Corps of the Public Health Service, Coast Guard, and the National Oceanic and Atmospheric Administration).

Claim: A request for payment for benefits received or services rendered.

Claims Review: Review of claims by government, medical foundations, PSROs, insurers or others responsible for payment to determine liability and amount of payment. This review may include determination of the eligibility of the claimant; the eligibility of the provider that the benefit is covered; that the benefit is not payable under another policy; and that the benefit was necessary and of reasonable cost and quality.

Claims Services Only: A CSO plan is a contract designed for fully self-insured employers that need very little administrative assistance. Under a CSO arrangement, the insurer administers only the claims portion of the plan.

Class of Risk: A body of subscribers ranked together as having common characteristics and subject to an equal chance of loss.

Complementary Benefits: A program of benefits designed to fill out or complete to a desired maximum the benefits offered by another program.

Coinsurance: An arrangement under which the insured person pays a fixed percentage of the cost of medical care. For example, an insurance plan might pay 80% of the "allowable charge," with the insured individual being responsible for the remainder.

Consolidated Billing: A single billing prepared by a Control Plan to cover all employees of a national account enrolled on a group basis.

Comprehensive Major Medical: A policy designed to give the protection offered by both a basic and a major medical health insurance policy. It is characterized by a deductible amount, a coinsurance feature and maximum benefits.

Community Hospital: A non-profit hospital established to serve a specific geographic area.

Community Rating: A method of determining premiums for health insurance which ensures that all subscribers or a particular class of subscribers pay the same rate for the same level of benefits and that anticipated costs are spread evenly among all contracts.

Concurrent Review: The review of inpatient hospitalization to assure it remains the most appropriate setting for the care being rendered.

Consideration: One of the elements for a binding contract. Consideration is acceptance by the insurance company of the payment of the premium and the statement made by the prospective policyholder in the application.

Contingency Reserves: Reserves set aside by an insurance company for unforeseen or unplannable circumstances and expenses other than the normal losses incurred by the risks insured.

Continued Stay Review: Review during a patient's hospitalization to determine the medical necessity and appropriateness of continuation of the patient's stay at a hospital level of care. It may also include assessment of the quality of care being provided.

Contract: *a)* a legal agreement between an individual subscriber or a group, and a Plan expressing the benefits and limitations of the coverage to which a subscriber is entitled. The subscriber's contract consists of the certificate, endorsements, riders, and identification card; *b)* a legal agreement between a Plan and a hospital.

Contracting Hospital: A hospital which has contracted with one or more Plans to provide certain hospital services to members and which guarantees to provide such hospital service.

Contributory: A group insurance plan issued to an employer under which both the employer and employee contribute to the cost of the plan.

Control Plan: A Blue Cross or Blue Shield Plan which serves as headquarters for a National Account group. A Control Plan determines rates, consolidates multi-Plan bills and, in some cases, reimburses Plans who service members of that particular group account.

Conversion Privilege: A privilege granted in an insurance policy to convert to a different plan of insurance without providing evidence of insurability. The privilege granted by a group policy is to convert to an individual policy upon termination of group coverage.

Coordination of Benefits (COB): The anti-duplication provision to limit benefits for multiple group health insurance in a particular case to 100% of the expenses covered and to designate the order in which the multiple carriers are to pay benefits.

Copayment: A type of cost sharing whereby insured or covered persons pay a specified flat amount per unit of service or unit of time (e.g., $10 per visit, $25 per inpatient hospital day), their insurer paying the rest of the cost. The copayment is incurred at the time the service is used. The amount paid does not vary with the cost of the service (unlike coinsurance, which is payment of some percentage of the cost).

Cost-Plus Rating: A way of determining the cost of insurance that includes the cost of the benefits (or incurred claims) plus administrative costs, plus a contribution to the carrier's contingency reserve.

Cost-Based or Cost-Related Reimbursement: One method of payment of medical care by third parties for services delivered to patients. In cost-related systems, the amount of the payment is based on the costs to the provider of delivering the service. The actual payment may be based on any one of several different formulae, such as full cost, full cost plus an additional percentage, allowable costs, or a fraction of costs. Other reimbursement arrangements are based on the charges for the services delivered, or on budgeted or anticipated costs for a future time period (prospective reimbursement).

Cost Sharing: Provisions of a health insurance policy which require the insured or otherwise covered individual to pay some portion of covered medical expenses. Forms of cost-sharing are deductibles, coinsurance and copayments. A deductible is a set amount which a person must pay before any payment of benefits occurs. A copayment is a fixed amount to be paid with each service. Coinsurance is payment of a set portion of the cost of each service. In addition to being used to reduce premiums, cost sharing is used to manage utilization of covered services, for example, by requiring a large copayment for a service which is likely to be overused.

Covered Services: Hospital, medical, and other health care expenses incurred by the insured that entitle him to a payment of benefits under a health insurance policy. The term defines the type and amount of expense which will be considered in the calculation of benefits.

Credibility: The degree to which an account's experience or claims expense level may be expected to repeat itself.

Current Procedural Terminology (CPT): A system of terminology and coding developed by the American Medical Association that is used for describing, coding and reporting medical services and procedures.

D

Deductible: An amount the insured person must pay before payments for covered services begin. For example, an insurance plan might require the insured to pay the first $250 of covered expenses during a calendar year before the insurance company will begin payment.

Deferred Premium: An alternative premium arrangement whereby, instead of being fully prepaid, the full premium is deferred until the group's claims experience justifies it.

Deficit Reduction Act of 1984: DEFRA helps prevent discrimination against elderly employees in health insurance, particularly in regard to extending the provisions of TEFRA. It requires group health plans to be offered to employees' depedents in the 65–69 age bracket, even if the employees are not in that age bracket.

Dependent: Person (spouse or child) other than the subscriber who is covered in the subscriber's benefit certificate.

Diagnoses Code: A numerical classification descriptive of diseases, injuries and causes of death: International Morbidity Code, Manual of the International Statistical Classification of Diseases, injuries and AMA Standard Nomenclature of Disease, etc.

Diagnosis-Related Groups (DRGs): System that reimburses health care providers fixed amounts for all care given in connection with standard diagnostic categories.

Disability: Physical or mental handicap resulting from sickness or injury.

Disability Income Insurance: A form or insurance that provides periodic payments to replace income when an insured person is unable to work as a result of illness, injury or disease.

Discharge Planning: The process of assessing a patient's needs for medically appropriate treatment after hospitalization and effecting an appropriate and timely discharge.

Dread Disease Insurance: Insurance providing a maximum amount for expenses incurred in connection with the treatment of specified diseases, such as cancer, poliomyelitis, encephalitis or spinal meningitis.

Dual Choice: An employee choice of more than one health insurance or health program to provide health services, usually a health insurance program and a prepaid group practice (HMO) or PPO to choose from.

Duplication of Benefits: Overlapping or identical coverage of the same insured under two or more health plans, usually the result of contracts of different insurance companies, service organizations, or pre-payment plans; also known as multiple coverage.

E

Earned Premium: That portion of a policy's premium payment for which the protection of the policy has already been given. For example, an insurance company is considered to have earned 75% of an annual premium after a period of nine months of an annual term has elapsed.

Effective Date: The date on which the insurance under a policy begins.

Elective Surgery: Surgery which need not be performed on an emergency basis, because reasonable delays will not affect the outcome of surgery unfavorably. Such surgery is usually necessary and may be major.

Eligible Employees: Those members of a group who have met the eligibility requirements under a group life or health insurance plan.

Emergency Care: Care for patients with severe or life-threatening conditions that require immediate intervention.

Employee Retirement Income Security Act of 1974: Primarily enacted to effect pension equality, ERISA also contains provisions to protect the interests of group insurance plan participants and beneficiaries. It requires, among other things, that insurance plans be established pursuant to a written instrument that describes the benefits provided under the plan, names the persons responsible for the operation of the plan, and spells out the arrangements for funding and amending the plan.

Enabling Acts: Laws passed by a State legislature which allow the formation of a non-profit health care plan.

Endorsement: A provision added to a subscriber certificate whereby the scope of its coverage is changed.

Enrollment Card: A document signed by an employee as notice of desire to participate in the benefits of a group insurance plan.

Enrollment Period: Period during which individuals may enroll for insurance benefits. Most contributory group insurance has an annual enrollment period when members of the group may elect to begin contributing and become covered.

Equalization: Program for enrolling and servicing national accounts on the basis of a uniform inter-Plan consolidated retention.

Equalized Billing: Coordination of Plans for the purpose of providing comparable or identical benefits at a common rate to members of a national account.

Equitable Rates: Insurance costs which are fairly divided, equally among all classes of insured. Equity requires that each class of insured should pay enough to carry its fair share of the loss and expenses.

Equity: An insurance rate-making guideline that each class of insured should pay enough to carry its fair share of the loss and expenses. It is concerned with the fairness of the rate from class to class. Equity states that a high risk class or a class with a certain level of benefits should not be subsidized by a low-risk class or insured individuals who have chosen a different benefit level.

Evidence of Insurability: Statement of a person's physical condition and/or other factual information affecting his acceptance for insurance.

Exclusions: Specific conditions or circumstances listed in the policy for which the policy will not provide benefit payments.

Exclusive Provider Organization: An EPO is a more rigid type of PPO that requires the employee to use only designated providers or sacrifice reimbursement altogether. PPOs encourage employees to use "preferred" providers through more generous reimbursement, but will still reimburse for nonpreferred providers.

Expenses Incurred: Operating expenses, other than case (claim) costs, paid and unpaid, for which a Plan became liable during a given accounting period.

Experience: The extent of Plan benefits usage by subscribers.

Experience Rating: The determination of the subscriber dues for a group or class of risk partially or wholly on the basis of that group or class of risk's own experience.

Explanation of Benefits: A form sent to the insured person after a claim for payment has been processed by the insurance company that explains the action taken on that claim. This explanation might include the amount that will be paid, the benefits available, reasons for denying payment, the claims appeal process, and so forth.

Exposure: The state of being subject to a chance of loss.

F

Factoring: The practice of one individual or organization selling its accounts receivable (unpaid bills) to a second at a discount. The latter organization, called the 'factor', usually assumes full risk of loss if the accounts prove uncollectible. In health services delivery, the expression generally refers to a hospital's or physician's sale of unpaid bills to a collection agent.

Fee for Service: Method of charging whereby a physician or other practitioner bills for each encounter or service rendered. This system contrasts with salary, per capita or prepayment systems, where the payment is not changed with the number of services actually used.

Fee Schedule: A listing of accepted charges or established allowances for specified procedures. It represents a physician's or third party's standard or maximum charges for the listed procedures.

Final Billing: The last of a series of claims a hospital submits to the Plan for a continuous-stay patient. Final billing is done when the patient is discharged, deceased, or when benefits are exhausted.

First-Dollar Coverage: Insurance that pays virtually all of the full cost of covered services, with little or no cost sharing (deductible, coinsurance, or copayment) by the insured patient.

Fiscal Agent or Intermediary: A contractor that processes and pays provider claims on behalf of a State Medicaid agency. Fiscal agents are rarely at risk, but rather serve as an administrative unit, handling the payment of bills. Fiscal agents may be insurance companies, management firms, or other private contractors. Medicaid fiscal agents are sometimes also Medicare carriers or intermediaries.

Flat Schedule: Everyone in a group is insured for the same benefits regardless of salary, position, or other circumstances.

Foundations for Medical Care: A forerunner program to utilization review, these watchdog organizations were established in the early 1960s for recipients of Medicare.

Fractionation: The practice of charging separately for several services or components of a service.

Franchise Insurance: A form of insurance in which individual policies are issued to the employees of a common employer or the members of an association under an arrangement by which the employer or association agrees to collect the premiums and remit them to the insurer.

Fraternal Insurance: A cooperative type of insurance provided by social organizations for their members.

Fraud: Intentional misrepresentation by either providers or consumers to obtain services or payment for services. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received. Fraud is illegal and carries a penalty when proven. See also **Abuse**.

Free-Standing Surgical Center: A health care facility staffed by licensed physicians which is designed to handle surgical procedures that do not require overnight hospital care.

Funded: In insurance, having sufficient funds to meet future liabilities. Can also be used in speaking of trust funds for social insurance programs. Capital depreciation is said to be funded if the amounts included in an institution's reimbursements for capital depreciation are set aside in a fund used for capital purposes rather than being spent on current operating costs.

G

Grace Period: A period of time after the premium due date during which a group or non-group subscriber may pay without jeopardizing coverage.

Group: A body of subscribers eligible for group insurance by virtue of some common identifying attribute, such as common employment by an employer, or membership in a union, association or other organization.

Group Contract: A contract of insurance made with an employer or other entity that covers a group of persons identified by reference to their relationship to the entity.

Group Insurance: An insurance plan by which a number of employees (and their dependents), or members of a similar homogeneous group, are insured under a single policy, issued to their employer or the group with individual certificates of insurance given to each insured individual or family. Individual employees may be insured automatically by virtue of employment, only on meeting certain conditions (employment for over a month for example), or only when they elect to be insured. The policyholder or insured is the employer, not the employees.

Group Practice: Physicians or other health professionals providing services with income pooled and redistributed to the members of the group according to some prearranged plan. Groups vary in size, composition and financial arrangements.

Guaranteed Renewable Contract: A contract that the insured person or entity has the right to continue coverage by the timely payment of premiums for a period of time, during which period the insurer cannot change the contract, other than in the premium rate.

H

Hazard: A situation or event which introduces or increases the probability of occurrence of a loss arising from a peril, or that increases the extent of a loss; such as slippery floors, unsanitary conditions, or congested traffic.

Health Maintenance Organization (HMO): An organization that provides a wide range of comprehensive health care services for a specified group at a fixed periodic payment.

Health Risk Appraisal: A survey used by employers to determine the likelihood of an insured experiencing death, illness, or injury in the future. It helps employers decide whether wellness and other preventive care programs are necessary.

Health Statement: A form which an applicant completes attesting to his and dependents' health in order to secure health insurance.

High Self-Insured Deductible: HSID is a way for employers to improve cash flow by self-funding the first tier of any employee's health care expenses. Employers can thus retain funds that would normally be paid to the insurance company to cover current and future claims.

Home Health Care: Health services rendered to an individual as needed in the home. Such services are provided to aged, disabled, sick or convalescent individuals who do not need institutional care. The services may be provided by a visting nurse association (VNA), home health agency, hospital or other organized community group. They may be quite specialized or comprehensive (nursing services, speech, physical, occupational and rehabilitation therapy, homemaker services, and social services).

Homemaker Services: Non-medical support services (e.g., food preparation, bathing) given a homebound individual who is unable to perform these tasks himself. Homemaker services are intended to preserve independent living and normal family life for the aged, disabled, sick or convalescent.

Home Plan: A Plan participating in the Inter-Plan Service Bank whose subscriber is hospitalized in the area of another Bank Plan.

Hospice: A program which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's physician. The whole family is considered the unit of care. Emphasis is on symptom control and support before and after death.

Hospital: An institution whose primary function is to provide inpatient services, diagnostic and therapeutic, for a variety of medical conditions, both surgical and nonsurgical. In addition, most hospitals provide some outpatient services, particularly emergency care. Hospitals are classified by length of stay (short-term or long-term); as teaching or nonteaching; by major type of service (phychiatric, tuberculosis, general and other specialties, such as maternity, childrens' or ear, nose and throat); and by control (government, Federal, State or local, for-profit and non-profit). The hospital system is dominated by the short-term, general, non-profit community hospital.

Hospital-Based Physician: A physician who spends the predominant part of time within hospitals instead of in an office setting. Such physicians sometimes have a special financial arrangement with the hospital (salary or percentage of fees collected), and include directors of medical education, pathologists, anesthesiologists and radiologists, as well as physicians who staff emergency rooms and outpatient departments.

Hospital Income Insurance: A type of disability insurance providing cash benefits to insureds based upon the number of days of hospital confinement.

Hospital Indemnity: A form of health insurance which provides a stipulated daily, weekly or monthly indemnity during hospital confinement. The indemnity is payable without regard to the actual expense of hospital confinement.

Host Plan: A Plan participating in the Inter-Plan Service Bank through which hospital care is extended to a subscriber of another Bank Plan.

I

Indemnity: Benefits paid in a predetermined amount in the event of a covered loss.

Identification Card (I.D.): The card issued by the Plans to the subscriber as evidence of membership. It shows name, number, types of coverage and effective date.

Incidence: The number of cases of disease or infection in relation to the unit of population in which they occur over a period of time.

Incur: To become liable for a loss, claim or expense.

Incurred But Not Reported: Claims that have been incurred but have not been reported to the insurer as of some specific date.

Indemnity, Indemnity Benefits: Benefits in the form of cash payments rather than services. In most cases, after the provider of service has billed the patient, the insured person is reimbursed by the company (Indemnity benefits are contrasted with service benefits.)

Indemnity Schedule: Predetermined allowances for each medical and surgical procedure.

Individual Case Management: For patients that have the potential to be high-cost, long-stay, and/or complicated discharge planning cases; to locate and assess medically appropriate alternative settings for these patients; and to manage their health care benefits as cost-effectively as possible. This may include the provision of extra-contractual benefits when necessary.

Individual Practice Association (IPA): A partnership, corporation, or association which has entered into an arrangement for provision of their services. The term originated in the Health Maintenance Organization Act of 1973. IPAs are one source of professional services for HMOs and are modeled after medical foundations.

Individual Practice Plan: Usually synonymous with a medical foundation. Sometimes used to refer to an HMO which obtains its professional services from an individual practice association.

In-Patient: A subscriber who occupies a hospital bed while receiving hospital care, including room, board and general nursing care.

Insurable Risk: The conditions that make a risk insurable are: *a)* the peril insured against must produce a definite loss not under the control of the insured, *b)* there must be a large number of homogeneous exposures subject to the same perils, *c)* the loss must be calculable and the cost of insuring it must be economically feasible, *d)* the peril must be unlikely to affect all insureds simultaneously, *e)* the loss produced by a risk must be definite and have a potential to be financially serious.

Insurance: Protection by written contract against the financial hazards (in whole or in part) of the happenings of specified fortuitous events.

Insurance Commissioner: The State official charged with the enforcement of laws pertaining to insurance in the respective States. The commissioner's title, status in government and responsibilities differ somewhat from State to State.

Insurance Pool: *a)* an organization of insurers or reinsurers through which particular types of risks are shared or pooled. The risk of high loss by any particular insurance company is transferred to the group as a whole (the insurance pool) with premiums, losses, and expenses shared in agreed amounts. The advantage of a pool is that the size of expected losses can be predicted for the pool with much more certainty than for any individual party to it. Pooling arrangements are often used for catastrophic coverage or for certain high risk populations. Pooling may also be done within a single company by pooling the risks insured under various different policies so that high losses incurred by one policy are shared with others; *b)* a group of insured individuals usually with some common characteristics who form a generic group large enough to serve as a base for actuarial evaluation and risk analysis.

Integration: A coordination of the disability income insurance benefit with other disability income benefits, such as Social Security, through a specific formula to ensure reasonable income replacement.

Intermediary: A public or private agency or organization selected by providers of health care which pays claims and performs other functions with respect to such providers.

Intermediate Care Facility (ICF): An institution which is licensed under State law to provide health-related care and services to individuals who do not require the degree of care or treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services above the level of room and board.

Inter-Plan Service Benefit Bank: Makes hospital service available to Blue Cross members when it becomes necessary for them to enter a hospital in a Plan area outside the one in which the member is enrolled. A participating Plan is the "Home Plan" whose member is hospitalized in the area of another Bank Plan. It acts as a "Host Plan" when it extends benefits to a member of another Bank Plan hospitalized in its area.

Inter-Plan Tranfer: The transfer of membership from one Plan to another.

Inter-Plan Transfer Agreement: The operating agreement regarding transfers between Plans.

L

Lag Time Premium Arrangements: An alternative premium arrangement which allows the account to pay the premium later than normal.

Lapse: Termination of a policy upon the policyholder's failure to pay the premium within the time required.

Last Dollar Coverage: Insurance coverage without upper limits or maximums no matter how great the benefits payable.

Left Employ: A subscriber who has terminated employment in the group through which his membership was maintained.

Legal Reserve: The minimum reserve which a company must keep to meet future claims and obligations as they are calculated under the state insurance code.

Legend Drugs: Prescription drugs.

Length of Stay (LOS): The length of an inpatient's stay in a hospital or other health facility. It is one measure of use of health facilities, reported as an average number of days spent in a facility per admission or discharge.

Level Premium: A premium which remains unchanged throughout the life of a policy.

Licensed Practical Nurse (LPN): A nurse who has practical experience in the provision of nursing care but is not a graduate of a degreed program of nursing education.

Lifetime Maximum: Maximum amount that Major Medical will pay toward a subscriber's claim in a lifetime. The amount varies depending on the type of coverage the subscriber carries.

Lifetime Reserve: A reserve of inpatient hospital care available over an individual's lifetime that the individual may use after he has used the maximum days allowed in a single benefit period.

Limited Policy: A contract which covers only certain specified diseases or accidents.

Loading: The amount added to the actuarial value of the coverage (expected or average amounts payable to the insured) to cover the expense to the insurer of securing and maintaining the business, i.e., the amount added to the pure premium needed to meet anticipated liabilities for expenses, contingencies, profits or special situations.

Local Benefit Agreement (LBA): An operating agreement for enrolling and servicing National Account subscribers on the basis of the local Plan benefits and uniform inter-Plan and consolidation billing.

Long-Term Care: Services required by persons who are chronically ill, aged, disabled, or retarded, in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing homes, homes for the retarded and mental hospitals.

Loss: In insurance, the basis for a claim under the terms of an insurance policy. Any diminution of quantity, quality or value of property, resulting from the occurrence of some peril or hazard.

Loss Ratio: The relationship between case, costs, and subscriber dues for the same period and on the same accounting basis; e.g., incurred in the calendar year, paid in the calendar year, etc.

M

Major Medical Insurance: Health insurance to finance the expense of major illness and injury. Characterized by large benefit maximums, the insurance, above an initial deductible, reimburses the major part of charges for hospital, doctor, private nurses, medical appliances, prescribed out-of-hospital treatment, drugs and medicines. The insured person as co-insurer pays the remainder.

Manual Rate: The premium rate developed for a group insurance coverage from the company's standard rate tables normally referred to as its rate manual or underwriting manual.

Marginal Cost: The change in the total cost of producing services which results from a unit change in the quantity of services being produced. Economies of scale will result from the expansion of a program when marginal cost is less than average or unit cost.

Master Contract: A legal agreement with an employer under which individual certificates are issued to his employees.

Matrix Contract: Group contract that allows for variability in benefit products.

Medicaid: State programs of public assistance to persons whose income and resources are insufficient to pay for health care. Title XIX of the federal Social Security Act provides matching federal funds for financing state Medicaid programs, effective January 1, 1966.

Medically Not Necessary: Use of this term does not necessarily mean the physician who performed the service in question is not providing appropriate medical care, only that the physician and insurance company disagree on the patient's need for a particular medical service,that the insurance company usually does not pay for the particular service in question, that the treatment is too new and innovative, or that there is another reason for nonpayment.

Medicare: The federal government's hospital and medical insurance program for the aged, totally disabled, and those with end-stage renal disease.

Medical Foundation: An organization of physicians, generally sponsored by a State or local medical association. Sometimes called a foundation for medical care. It is a separate and autonomous corporation with its own board of directors. Physician members of the medical society may apply for membership in the foundation and, upon acceptance, participate in its activities. A foundation believes in the free choice of a physician and hospital by the patient, fee-for-service reimbursement and local peer review. Many foundations operate as prepaid group practices or as an individual practice association for an HMO. While these are prepaid on a capitaion basis for services to some or all of their patients, they still pay their individual members on a fee-for-service basis for the services they give. Some foundations are organized for peer review purposes or other specific functions.

Medigap Policy: A health insurance policy designed to supplement Medicare coverage.

Merit Rating: Used for most large groups to determine the premium rate. The "merit rating" formula takes into consideration the group's utilization of benefits, location, sex, and age distribution. See "Experience Rating."

Minimum Group: The least number of employees permitted under a state law to effect a group for insurance purposes; the purpose is to maintain some sort of proper division between individual policy insurance and group insurance.

Minimum Premium Plan: An MPP is another way of self-funding to improve cash flow, whereby the employer assumes responsibility for funding most benefits and the insurer assumes liability for benefits above a predetermined level.

Miscellaneous Expenses: Hospital charges other than room and board, such as X-rays, drugs, laboratory fees and other ancillary charges. (Sometimes referred to as Ancillary Charges.)

Morbidity: The incidence and severity of sicknesses and accidents in a defined class or classes of persons.

Multiple Employer Trust (MET): A legal trust established by a plan sponsor that brings together a number of small, unrelated employers for the purpose of providing group medical coverage on an insured or self-funded basis.

Mutual Insurance Company: Insurance companies with no capital stock, owned by the policyholders. Trustees of the company are chosen by the policyholders. Earnings over and above payment of losses, operating expenses, and reserves are the property of the policyholders and returned to them in some way such as dividends or reduced premiums. See also **Stock Insurance Company**.

N

National Account: A company with employment in more than one Plan area.

National Association of Insurance Commissioners (NAIC): The association of insurance commissioners of various states formed to promote national uniformity in the regulation of insurance.

National Management Information System (NMIS): System used to monitor how effectively the Blue Cross and Blue Shield network meets the service expectations of its customers. NMIS measures factors relating to membership, inquiry, claims processing, etc.

Noncancellable Guaranteed Renewable Policy: An individual policy under which the insured person has the right to continue in force until a specified age, such as to age 65, by the timely payment of premiums.

Noncontributory: A term applied to employee benefit plans under which the employer bears the full cost of the benefits for the employees.

Nondisabling Injury: An injury which may require medical care, but does not result in loss of working time or income.

Non-Group: Subscribers enrolled in a Plan other than in a group (e.g., direct pay or individual coverage).

Nonoccupational Policy: Contract which insures a person against off-the-job accident or sickness. It does not cover disability resulting from injury or sickness covered by Workers' Compensation.

Nonparticipating Insurance: Insurance under which the policyholder is not entitled to share in the dividend distribution of the company.

Nonprofit Insurers: Institutions organized under state laws to provide hospital, medical or dental insurance on a nonprofit basis.

O

Old Age, Survivors' and Disability Insurance Act: The 1965 amendment to OASDI established Medicare, effective July 1966.

Optionally Renewable Contract: A contract of health insurance in which the insurer reserves the right to terminate the coverage at any anniversary or, in some cases, at any premium due date, but does not have the right to terminate coverage between such dates.

Out-of-Pocket Maximum: OOP maximum refers to the maximum amount that an insured employee will have to pay for expenses covered under the plan. It is usually $500 or $1,000.

Out-of-Pocket Payments: Those borne directly by a patient including payments under cost-sharing provisions.

Outpatient: A patient who is receiving ambulatory care at a hospital or other health facility without being admitted to the facility.

Outpatient Medical Facility: A facility designed to provide health and medical services to individuals who do not require hospitalization.

Over-the-Counter Drug (OTC Drug): A drug which is advertised and sold directly to the public without a prescription (e.g., aspirin).

P

Partial Disability: The result of an illness or injury which prevents an insured from performing one or more regular job functions.

Participating Plan: Plan which services a National Account. Depending on the type of national group, the Participating Plan may create bills for local members, retain claims records on local members or bill Control Plan for claims paid.

Patient Mix: The numbers and types of patients served by a hospital or other health program. Patients may be classified according to socioeconomic characteristics, diagnoses, or severity of illness.

Peer Review: The evaluation by physicians or other professionals of the effectiveness and efficiency of services ordered or performed by other members of the profession whose work is being reviewed (peers).

Per Diem Cost: Literally, cost per day. Generally refers to inpatient institutional costs per day or for a day of care.

Peril: Cause of a possible loss; such as an accident, death, sickness, fire, flood, or burglary.

Policy: The legal document issued by the company to the policyholder which outlines the conditions and terms of the insurance; also called the policy contract or the contract.

Preadmission Certification: Review of the need for proposed inpatient service(s) prior to time of admission to an institution.

Preadmission Review: The assessment of medical necessity and appropriateness of elective hospital admissions before hospitalization has occurred.

Pre-Admission Testing: PAT is a mechanism intended to reduce hospital stays by encouraging employees to have routine hospital testing done on an outpatient basis before being admitted to the hospital. Reimbursement is sometimes made on a more generous basis for PAT.

Pre-Existing Condition: A physical and/or mental condition of an insured which first manifested itself prior to the issuance of his policy or which existed prior to issuance and for which treatment was received.

Preferred Provider Arrangement: A PPA differs from a PPO in that it is an agreement between providers and another entity, whereas a PPO is an organization of providers.

Preferred Provider Organization (PPO): An arrangement whereby a third-party payor contracts with a group of medical care providers who furnish services at lower than usual fees in return for prompt payment and a certain volume of patients.

Premium: The amount of money the insured person (and/or the insured person's employer) pays the insurance company for enrollment in an insurance plan.

Prepaid Group Practice Plan: A plan under which specified health services are rendered by participating physicians to an enrolled group of persons, with a fixed periodic payment in advance made by or on behalf of each person or family. Such a plan is one form of Health Maintenance Organization (HMO).

Prepaid Health Plan (PHP): A contract between an insurer and a subscriber or group of subscribers whereby the PHP provides a specified set of health benefits in return for a periodic premium.

Preventive Medicine: Care which has the aim of preventing disease or its consequences. It includes programs aimed at warding off illnesses (e.g., immunizations), early detection of disease and inhibiting further deterioration of the body, including the promotion of health through altering behavior, especially by health education. Preventive medicine is also concerned with improving the healthfulness of our environment and our relations with it.

Primary Care: The point when the patient first seeks assistance from the medical care system and the care of the simpler and more common illnesses. The primary care provider usually also assumes ongoing responsibility for the patient in both health maintenance and therapy of illness.

Primary Payer or Primary Carrier: Denotes the insurer obligated to pay losses prior to any liability of other, secondary insurers.

Prior Authorization: Requirement of a third party, under some systems of utilization review, that a provider justify the need for delivering a particular service to a patient before providing the service in order to receive reimbursement. Generally, prior authorization is required for non-emergency services which are expensive (involving a hospital stay, preadmission certification, for example) or particularly likely to be overused or abused.

Professional Liability: Obligation of providers or their professional liability insurers to pay for damages resulting from the acts of omission or commission in treating patients. The term is sometimes preferred by providers to medical malpractice because it does not necessarily imply negligence.

Professional Standards Review Organization (PSRO): A physician-sponsored organization charged with comprehensive and ongoing review of services. The purpose of this review is to determine whether services are: medically necessary; provided in accordance with professional criteria, norms and standards; and in the case of institutional services, rendered in an appropriate setting.

Proprietary: Owned and operated for the purpose of making a profit.

Proprietary Hospital: A hospital operated for the purpose of making a profit for its owners. Proprietary hospitals may be owned by physicians for the care of their own and others' patients. There is also a growing number of investor-owned hospitals, usually operated by a parent corporation which may operate a chain of such hospitals.

Proration: The adjustment of benefits paid because of a mistake in the amount of the premiums paid or the existence of other insurance covering the same accident or disability.

Prospective Payment System: A standardized payment system implemented in 1983 by Medicare to help manage health care reimbursement. Hospitals can expect a fixed reimbursement based not on the number and kinds of services delivered but on the diagnosis of the patient.

Prospective Rating: A method to develop a rate that generates premium income to support probable future experience. A prospective group rating approach determines a rate based on a group's own past experience and projects that into the coming policy year.

Prospective Reimbursement: Any method of paying hospitals or other health programs in which amounts or rates of payment are established in advance for the coming year and the programs are paid these amounts regardless of the costs they actually incur. These systems of reimbursement are designed to introduce a degree of constraint on charge or cost increases by setting limits on amounts paid during a future period. In some cases, such systems provide incentives for improved efficiency by sharing savings with institutions that perform at lower than anticipated costs. Prospective reimbursement contrasts with the method of payment where institutions are reimbursed for actual expenses incurred, i.e., on a retrospective basis.

Provider: An individual or institution which gives medical care.

Public Health: The science dealing with the protection and improvement of community health. Immunizations, sanitation, preventive medicine, quarantine and other disease control activities, occupational health and safety programs, assurance of the healthfulness of air, water and food, health education, and epidemiology are recognized public health activities.

Q

Qualified Impairment Insurance: A form of special class insurance which restricts benefits for the insured person's particular condition.

Quality Assurance: Activities and programs intended to assure the quality of care in a defined medical setting or program.

Query: (Blue Cross and Blue Shield) A request for eligibility information or claims approval from another Plan. (Medicare) Communications between a carrier and SSA determining eligibility and deductible information on Medicare recipients.

R

Rating: The process of determining rates, or the cost of insurance, for individuals, groups or classes of risks.

Rating Period: The period of time covered by the group policy or master contract.

Reasonable and Customary Charge: R&C charge refers to the maximum amount an insurer will reimburse for medical care expenses covered under group health insurance plans.

Recurring Clause: A provision in some health insurance policies which specifies a period of time during which the recurrence of a condition is considered a continuation of a prior period of disability or hospital confinement.

Regulation: The intervention of government in the market to control entry into or change the behavior of participants in that marketplace through specification of rules for the participants.

Rehabilitation: *a)* restoration of a disabled person to a meaningful occupation, *b)* a provision in some disability policies that provides for continuation of benefits or other financial assistance while a disabled insured is retraining or attempting to resume productive employment.

Reinstatement: The resumption of coverage under a policy which has lapsed.

Reinsurance: The acceptance by one or more insurers, called reinsurers, of a portion of the risk underwritten by another insurer who has contracted for the entire coverage.

Relative Value Scale or Schedule (RVS): A coded listing of physician or other professional services using units which indicate the relative value of the various services they perform: taking into account the time, skill and cost required for each service. Appropriate conversion factors are used to translate the units into dollar fees for each service.

Remitting Agent: A person appointed by an employer to administer Blue Cross and Blue Shield coverage within the group. The remitting agent is not an employee of the Plans.

Reserves: Accounts set up to report the liabilities faced by an insurance company under outstanding insurance policies. The company sets the amount of reserves in accord with its own estimates, State laws, and recommendations of supervisory officials and national organizations. Reserves are obligated amounts and have four principle components: reserves for known liabilities not yet paid; reserves for losses incurred but unreported; reserves for future benefits; and other reserves for various special purposes, including contingency reserves for unforseen circumstances.

Retention: Money not used to pay claims. Elements of retention are: general office expense, claims administration expense, taxes, community subsidy, risk charge and contingency reserve.

Retention Rate: The percentage of the subscriber dues held by the Plan under experience rating for groups above the amount necessary to pay cases (claims).

Retrospective Rate Credit: If a retrospective-rated group experiences a lower claims usage by its members than were projected in its premium rates, a credit representing the unused premium is made available to the group at the time of their rate renewal.

Retrospective Reimbursement: Payment to providers by a third-party carrier for costs or charges actually incurred by subscribers.

Rider: A legal document which modifies the protection of an insurance policy, either expanding or decreasing its benefits, or adding or excluding certain conditions from the policy's coverage.

Risk: The probability of uncertainty economic loss. Also used to refer to the probability that the loss will occur.

Risk Charge: The portion of a premium which goes to generate or replenish surpluses which a carrier must develop to protect against the possibility of excessive losses under its policies.

Risk Management: A process used by individuals, business organizations, and insurers to limit their loss.

S

Second Surgical Opinion: SSO is a mechanism to reduce unnecessary surgery by encouraging individuals to seek a second opinion for elective surgery.

Self-Administration: The procedure where an employer maintains all records regarding the employees covered under a group insurance plan.

Self-Insure: The practice of an individual, group of individuals, employer, or organization assuming complete responsibility for losses which might be insured against, such as health care expenses. In such cases, health care expenses would be financed out of current income, savings or a fund developed for the purpose.

Senior Citizen Policies: Contracts insuring persons 65 years of age or over. In most cases these policies supplement the coverage afforded by the government under the Medicare program.

Service Benefits: Hospital and/or medical-surgical services available to a subscriber without fee-schedule limitation in terms of cost.

Socialized Medicine: A medical care system where the organization and provision of medical care services are under government control, and providers are employed by or contract for the provision of services directly with the government.

Special Care Units: Areas of a hospital that are devoted to the care of specific medical conditions. Such units commonly include Intensive (or Critical) Care Units, Coronary Care Units and Burns Units.

Specialty Boards: Organizations that certify physicians and dentists as specialists or subspecialists in various fields of medical and dental practice. The standards for certification relate to length and type of training and experience and include written and oral examination of applicants for specialty certification. The boards are not educational institutions and the certificate of a board is not considered a degree. Specialties and their boards are recognized and approved by the American Board of Medical Specialties in conjunction with the AMA Council on Medical Education.

Specified Disease Insurance: Insurance which provides benefits toward the treatment of the specific disease or diseases named in the policy.

Special Risk Insurance: Coverage for risks or hazards of a special or unusual nature.

Standard Provision: Those contract provisions generally required by the state statutes.

Standard Risk: A person who, according to a company's underwriting standards, is entitled to insurance protection without extra rating or special restrictions.

State Insurance Department: A department of a state government whose duty is to regulate the business of insurance and give the public information on insurance.

Stock Insurance Company: A company owned and controlled by stockholders and operated for the purpose of making a profit, as contrasted with a mutual insurance company. In the former the profits go to the owners, in the latter they go to the insured.

Stop-Loss Provision: In experience rating, a maximum dollar amount to minimize the impact of individual high cost claims. The maximum dollar amount is chargeable to a group with the cost of the amount over and above that maximum being spread to all groups.

Subrogation: Means by which claims are identified as the responsibility of another insurer since treatment of the condition resulted from the action of an outside party.

Subscriber: An individual (family head or employee) and eligible dependents.

Substandard Insurance: Insurance issued with an extra premium or special restriction to those persons who do not qualify for insurance at standard rates.

Substandard Risk: An individual, who, because of health history or physical limitations, does not measure up to the qualification of a standard risk.

Summary Plan Description: An SPD contains specific information about the health plan. Each plan participant and the Department of Labor must be provided with an SPD.

Supplemental Health Insurance: Health insurance which covers expenses not covered by separate health insurance already held by the insured, e.g., which supplements another insurance policy. For example, insurance to people covered under Medicare which covers either the costs of cost-sharing required by Medicare, services not covered, or both.

Surgical Care Center: A facility which serves outpatients requiring surgical treatment but not requiring hospitalization as an inpatient. Also known as ambulatory surgery.

Surgical Schedule: A list of dollar allowances which are payable for various types of surgery, based upon the severity of the procedure.

Syndicate: A group of participating Plans which provide a uniform contract to a national account.

T

Taft-Hartley Trusts: Groups whose health coverage results from a collective bargaining agreement.

Tax Equity and Fiscal Responsibility Act of 1982: TEFRA was enacted to prevent discrimination against elderly employees with regard to health insurance. It amended the Social Security Act to make Medicare secondary to employer group health plans for active employees and spouses aged 65 through 69. TEFRA also amended ADEA to require employers to offer employees and dependents aged 65 through 69 the same coverage available to younger employees.

Tertiary Care: Services provided by specialized providers (e.g., neurologists, neurosurgeons, thoracic surgeons, intensive care units). Such services frequently require sophisticated technological and support facilities.

Third-Party Administrator: TPA refers to a person or organization that provides certain administrative services to group benefits plans, including premium accounting, claims review and payment, claims utilization review, maintenance of employee eligibility records, and negotiations with insurers that provide stop-loss protection for large claims.

Third-Party Payer: Any organization that pays or insures health or medical expenses on behalf of beneficiaries or recipients (e.g., Blue Cross and Blue Shield Plans, commercial insurance companies, Medicare, and Medicaid). The individual or employer generally pays a premium for such coverage in all private and some public programs. The organization then pays bills on the patient's behalf; such payments are called third-party payments and are distinguished by the separation between the individual receiving the service (the first party), the individual or institution providing it (the second party) and the organization paying for it (the third party).

Time Limit: The period of time during which a notice of claim or proof of loss must be filed.

Title XVIII: The title of the Social Security Act which contains the principal legislative authority for the Medicare program, and therefore a common name for the program.

Title XIX: The title of the Social Security Act which contains the principal legislative authority for the Medicaid program, and therefore a common name for the program.

U

Unallocated Benefit: A policy provision providing reimbursement up to a maximum amount for the cost of all extra miscellaneous hospital services, but not specifying how much will be paid for each type of service.

Underwriting: The process by which an insurer determines whether or not and on what basis an application for insurance will be accepted; the process of selecting, classifying, evaluating and assuming risks according to their insurability.

Unearned Premium: That portion of the paid premium applying to the unexpired portion of the policy term; or that portion of the paid premium for which protection has not been received.

Uninsurable Risk: One not acceptable for insurance due to excessive risk.

Utilization Data: Factors describing health benefits used as to location, duration, type, cost, diagnosis, etc.

Utilization Rate: The frequency of usage as related to exposures.

Utilization Review: A mechanism used by some insurers and employers that evaluates health care on the basis of appropriateness, necessity, and quality. For hospital review, it can include preadmission certification, concurrent review with discharge planning, and retrospective review.

V

Voluntary Employees' Beneficiary Association: A VEBA, also known as a 501(c)(9) trust, is a method of funding an employee benefits plan. It is used almost exclusively by large employers.

W

Waiting Period: The length of time an employee must wait from his or her date of employment or application for coverage to the date their insurance becomes effective (sometimes called a probationary period).

Waiver: An agreement attached to a policy which exempts from coverage certain disabilities or injuries which are normally covered by the policy.

Waiver of Premium: A provision included in some policies which exempts the policyholder from paying the premiums while an insured is disabled.

Workers' Compensation: Insurance against liability to pay benefits for injuries incurred by employees in the course of or arising out of their employment.

Written Premiums: The entire amount of premiums due in a year for policies issued by an insurance company.

APPENDIX F

SUGGESTED STYLE FOR STICKERS ADVERTISING TPCP

SUGGESTED STYLE FOR STICKERS ADVERTISING TPCP

THIS ITEM WAS PURCHASED

USING FUNDS RECOVERED BY THE

KELLER ARMY COMMUNITY HOSPITAL

THIRD PARTY COLLECTION PROGRAM

Suggested Colors: Gold Background with Black letters

Suggested Size: 1 1/2" X 3"

APPENDIX G

JOB DESCRIPTION: INSURANCE COORDINATOR

PROPOSED JOB DESCRIPTION CHANGE: INSURANCE COORDINATOR

MAJOR DUTIES

1. Supervisor for the Third Party Collection Program (TPCP) for Keller Army Community Hospital. The program generates income which is used as a portion of the hospital operating fund. Income is reimbursement for medical care and treatment provided by the Keller Army Community Hospital, West Point, NY to military retirees and family members covered by civilian health insurance carriers.

1. The Supervisor of the TPCP is responsible to:

a. Supervise the TPCP Billing Technician in inpatient, outpatient and Medicare supplemental billing and collection procedures.

b. Prepare weekly reports for Resource Management Office, and monthly reports for Health Services Command (HSC).

c. Track delinquent accounts. Assign follow-up actions to billing clerk. Decide which accounts are uncollectible and forwarded to the treasurer for write off. Decide which accounts are forwarded to SJA or Finance and Accounting Office for further collection action.

d. Establish and implement Standard Operating Procedures (SOP's) for inpatient billing, outpatient billing, Medicare Supplemental insurance billing, and precertification and utilization review, using DOD directives when available, and conforming to insurance industry standards as applicable in Military Treatment Facilities (MTF'S). Review and update SOP's as required by changes in DOD regulations and insurance industry standards.

2. The incumbent is required to develop and maintain a community information program on TPCP by:

a. Providing written materials to hospital or Academy informational programs; formal briefings to groups; and information to individuals both orally and in writing upon request.

b. Writing articles for MEDDAC and USMA bulletins, and local newspapers to advertise changes and additions to the program.

3. The incumbent serves as primary point of contact with insurance company representatives. This requires the incumbent to:

a. Act as intermediary between physicians, the admission coordinator, and health insurance representatives to facilitate precertification and utilization review procedures in accordance with established SOP.

b. Contact health insurance company representatives to solve billing problems, or inquire concerning delayed, reduced or denied payments.

c. Attend local Patient Accounts Managers meetings as hospital representative to keep current on changes in insurance industry requirements and standards.

4. Research third party liability claims for SJA claims office as requested. Review inpatient and outpatient medical records and determine amount of charges for medical care provided to the claimant. Assign preparation of DA Form 2631 to the billing technician.

FACTOR 1: KNOWLEDGE REQUIRED

- Knowledge of current health insurance industry standards, federal laws, and military regulations, governing the use of health insurance practices as related to MTF's.

- Knowledge of general medical terminology.

- Ability to deal effectively with personnel at all levels of responsibility.

- Ability to express self clearly, both orally and in writing. Must be able to give group presentations.

- Ability to read, interpret and implement regulations, policies and directives based on analysis and sound judgement.

- Knowledge of computer systems.

- Proficiency in MS/Dos, wordprocessing, spreadsheets and databases.

FACTOR 2: SUPERVISORY CONTROLS

- Works under the general administrative supervision of the Chief of Patient Administration Division. Work is carried out independently. Establishes own priorities, and resolves problems by referring to available guidelines and operating procedures. Contacts HSC, or civilian counterparts to assist in resolving problems where no DOD directives or guidelines are available. Works in conjunction with the hospital treasurer who provides accounting support as required.

- Work is reviewed by Chief, PAD for adherence to federal law and Military regulations, and for timeliness of collections. Reports are reviewed by the treasurer for accuracy.

Factor 3: GUIDELINES

- The incumbent receives limited guidance from HSC, DOD Health Affairs, and the Office of the Surgeon General in the form of electronic messages, phone calls, and memorandums. Guidance is also available from insurance industry publications and local civilian patient accounts managers.

- The incumbent must use independent judgement in adapting available guidance for use in the MEDDAC, conforming to local health insurance industry standards and practices, and federal laws.

Factor 4: COMPLEXITY

- The incumbent is required to develop and implement a health insurance collection program combined with a public awareness program. Recommendations for changes are made to the MEDDAC command as changes in federal laws, and Army Regulations are made. The outcome must ensure a fast, efficient method of billing health insurance carriers to insure steady income for the hospital.

- The incumbent uses creative approaches to disseminate information to the patient population served by the hospital in a cost effective manner.

- The incumbent initiates contacts with local civilian patient accounts managers and insurance industry representatives to acquire and analyze current information on patient accounts management, and adapt procedures for use in the MEDDAC.

Factor 5: SCOPE AND EFFECT

- The TPCP generates income to supplement the MEDDAC budget. Implementation of efficient inpatient, outpatient, and Medicare supplemental billing procedures, and precertification and utilization review policies results in faster turnaround and increased collections. The whole MEDDAC is directly affected by the amount of funds available from the program for use in purchasing equipment and supplies.

Factor 6: PERSONAL CONTACTS

- Incumbent communicates orally and in writing with coworkers, patients, physicians, MEDDAC staff and command, HSC staff offices, Office of the Surgeon General, DOD Health Affairs Officers, Insurance Coordinators in other MEDDAC's, local health insurance representatives, and local civilian patient accounts managers.

Factor 7: PURPOSE OF CONTACTS

- Contact with coworkers is to assign tasks or solve problems. Contacts with patients, physicians and MEDDAC staff are to provide information and/or instructions concerning the use of health insurance in MTF's, and to brief commanders on the status of the program. Contacts with the HSC staff offices, Office of the Surgeon General, and DOD Health Affairs Officers are to acquire information about changes in Federal and Army Regulations, and to provide information concerning the efficiency and usefulness of recent changes in the program. Contacts with Insurance Coordinators in other MEDDAC's, local civilian patient accounts managers, and local insurance representatives are to exchange information about patient accounts management.

Factor 8: PHYSICAL DEMANDS

- Works in an office environment with periodic bending, lifting and sitting. Carrying of light papers is required. Physical visits to MEDDAC activities, local civilian hospitals, and insurance industry seminars is necessary.

FACTOR 9: WORK ENVIRONMENT

- Work is performed in an office setting, but may occasionally carry over into a health care setting.

APPENDIX H

JOB DESCRIPTION: INSURANCE BILLING TECHNICIAN

PROPOSED JOB DESCRIPTION: INSURANCE BILLING TECHNICIAN

MAJOR DUTIES

Serves as technician in support of the Third Party Collection Program (TPCP). This program generates income which is used as a portion of the hospital operating fund. Income is reimbursement are for medical care and treatment provided by the Keller Army Community Hospital, West Point, NY to military retirees and family members covered by civilian health insurance.

1. The technician is responsible for inpatient, outpatient and Medicare supplemental health insurance billing by:

a. Preparation and routing of health insurance bills generated by the MEDDAC computer system.

b. Daily collection of billing forms from outpatient clinics.

c. Daily processing of health insurance payments received.

2. The incumbent provides clerical support for the program and is responsible to:

a. Follow-up delinquent accounts by phone or in writing as assigned by the supervisor.

b. Copy inpatient and outpatient records as requested by health insurance companies for settlement of TPCP claims.

c. Type DA form 2631 for SJA third party liability claims, and maintains log of such claims sent to SJA for collection.

d. Maintain files of billing forms and appropriate correspondence.

e. Type additional correspondence as required.

3. The incumbent is responsible for screening emergency room treatment forms for possible third party liability claims, and maintains a log of possible claims sent to SJA for possible collection actions.

4. The incumbent serves as a point of contact for precertifcation and utilitization review in the absence of the supervisor.

FACTOR 1: KNOWLEDGE REQUIRED

- Knowledge of English grammar, spelling, and punctuation to correct obvious errors in materials being typed.

- Ability to express self clearly both orally and in writing.

- Ability to type 40 words per minute, with a working knowledge of MS Word or similar wordprocessing system.

- Knowledge of simple math calculations, and ability to operate an adding machine.

- Knowledge of general medical terminology helpful, but not required.

Factor 2: SUPERVISORY CONTROLS

Works under the general administrative and technical supervision of the TPCP supervisor who gives instructions on work to be accomplished. Work is carried out independently, refers problems or unusual situations to program supervisor. Work is spot checked for accuracy on a daily basis.

Factor 3: GUIDELINES

- Written and oral guidance is available from the supervisor. Accounting assistance and support is available from the hospital treasurer. Some interpretation of guidelines may be necessary to accomplish assigned tasks.

Factor 4: COMPLEXITY

- Prepares bills for mailing to health insurance companies, and processes payments received for open accounts. Work is assigned by the supervisor, but incumbent establishes own priorities for work to be accomplished. Incumbent must be familiar with local health insurance company requirements in order to screen bills and payments for accuracy.

- The incumbent uses established SOP's to take action on delinquent accounts assigned by the supervisor. Incumbent refers problems or unusual circumstances to the supervisor.

- The incumbent uses established SOP's to maintain files, type DA form 2631 for SJA claims office, and prepare additional correspondence as required.

Factor 5: SCOPE AND EFFECT

- The Third Party Collection Program generates income to supplement the MEDDAC budget. Accurate preparation of bills and efficient payment processing is required for fast turnaround of patient accounts. The whole MEDDAC is directly affected by the amount of funds available from the program for use in purchasing equipment and supplies.

Factor 6: PERSONAL CONTACTS

- Incumbent communicates orally with MEDDAC staff, and coworkers; orally and in writing with patients, and local health insurance representatives.

Factor 7: PURPOSE OF CONTACTS

- Contacts with coworkers and MEDDAC staff are in performance of duties. Contacts with patients are to extract health insurance information as necessitated by performance of duties. Contacts with local health insurance representatives are to exchange information about patient accounts, and facilitate settlement of open accounts.

Factor 8: PHYSICAL DEMANDS

- Works in an office environment with periodic bending, lifting and sitting. Carrying of light papers is required. Physical visits to MEDDAC activities may be necessary. Standing for extended periods when copying health records may be necessary.

Factor 9: WORK ENVIRONMENT

- Work is performed in an office setting, but may occasionally carry over into a health care setting.

APPENDIX I

TPCP SURVEY

KELLER ARMY COMMUNITY HOSPITAL THIRD PARTY COLLECTION PROGRAM

Do you have health insurance? If so, Keller Army Community Hospital would like to keep your information on file. That way, if you are ever admitted to the hospital, we will be able to complete the admission process quickly and efficiently, and you won't be bothered with a lot of questions when you aren't feeling well. All this information should appear on your insurance card. If you have more than one policy, please enter additional information in the blank space provided below. Please be sure to include information on Medicare and CHAMPUS Supplemental policies. Thank you for your help!

PLEASE PRINT CAREFULLY

YOUR NAME _____ *YOUR SSN _____

YOUR PHONE NUMBER (____)_____ BIRTHDATE _____

NAME OF YOUR INSURANCE COMPANY _____

INSURANCE COMPANY ADDRESS _____

INSURANCE COMPANY PHONE NUMBER _____

POLICY NUMBER _____ EFFECTIVE DATE _____

IF THIS IS A GROUP POLICY:

GROUP NAME AND NUMBER _____

Please return this form to the Treasurer's Office at Keller Army Community Hospital by folding on the lines indicated, taping closed, and dropping in the nearest mailbox. If you have questions about the Third Party Collection Program, please call Annette Zemek, Insurance Coordinator, at 914-938-3102. She'll be happy to assist you.

* AUTHORITY: Title 10, USC Section 4334, Directive AR 340-21. PRINCIPLE PURPOSE: To verify insurance information. ROUTINE USES: The information requested, including the Social Security Number (SSN) will be used for Official Use Only and will be maintained in accordance with Federal Law and regulations. MANDATORY OR VOLUNTARY DISCLOSURE AND EFFECTS OF NOT PROVIDING INFORMATION: Disclosure of SSN is voluntary. Failure to provide necessary information may preclude establishing accurate health care records.

•THIS SPACE IS PROVIDED FOR ADDITIONAL INFORMATION OR COMMENTS ABOUT THE THIRD PARTY COLLECTION PROGRAM.

DEPARTMENT OF THE ARMY
KELLER ARMY COMMUNITY HOSPITAL
ATTN: HSUD-PAD-TR
WEST POINT, NY 10996-1197

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ATTN HSUD-PAD-TR
WEST POINT NY 10996-1197

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APPENDIX J

ESTIMATE OF PROGRAM COSTS FOR TPCP

Estimate of program costs for TPCP

1. As requested, the following estimate of program costs for TPCP is provided. Estimate is for the 9 month period from 1 October 1990 to 1 July 1991.

Salary costs:	
Insurance Coordinator	15,125.00
Treasurer	4,800.00
NFA Student/Summer Hire	1,300.00
Equipment Costs:	
Computer	1,528.00
Calculator	47.98
Books	80.00
Survey Costs:	
Printing costs	300.00
Postage costs	1,700.00
TDY Costs: (paid by the Office of the Surgeon General)	
Insurance Coordinator	439.50
Treasurer	542.27
Phone Charges estimated at $10.00 per month	90.00
Postage costs estimated at $10.00 per month	90.00
Supply costs estimated at $20.00 per month	180.00
Total estimate of program costs	26,222.75

2. Gross total collections for this time period are $265,701.30.